			For	State of Ma	ryland / De	epartme		and M	-		nne.	20001		
			State Registrar 1. Decedent's Name (First, Middle, Las	nel .		Certifica	ate of Deat	h	2. Date of Deat	ag. No.	000	2. Time of Dooth		
	Physici		Jomarya Hou						Month OC	Day	2006	3. Time of Death		
	/Medic		4a. Facility Name (If not institution, give			4b. Ci	ty, Town, or Locatio	on of Death	Ψ	4c. Co	unty of Death	3.404		
			15 Tulip court			,	Baltime	,			Balter	none		
	uneral		5. Social Security Number 6. S	ex 7. Age □ M 2.5 €	(In yrs. last birthe	Month		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day	Xear)	9. Birthp Cour	olace (State or Foreign htry)		
	irector		Usual Residence of Decedent		62"	-			10.09.0	743		IND		
nylan	a how	_	10a. State 10b. County		10c. City, Town of						1	Od. Inside City Limits		
the M	28a-f	ecto	10e. Street and Number	more	bu	ltim	Zip Code		1	Og Citizen	of What Cour	1 ☐ Yes 2 ☑ No		
death with the Maryland	nd anywores dother then "natural", or liems 23a or 28a-f show event, the Madical Examiner must be notified at	Completed by Funeral Director	15 Tulip Court			101.	2/22	1		og. Onzon	USA			
r deat	er a	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was De	cedent of Hispanic (pecify Cuban, Mexic	Origin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,			
0036 hours after	l', or li	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:	0	1 🗆 Yes	2 No Speci	ity:		Sp	ecity: Blo	CK		
5-00 2 bou	ical E	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. D	ecedent's U	sual Occupation work done during m	aget of worki	00	16b. Kind	of Business/In			
1215- within 72	hen 'r	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ife. DO NOT	use retired)		ng	SOCI	711	curity		
Q 20	ther t	S	17. Father's Dame (First, Middle, Last)	Lyears	Coy	npute			(First, Middle, I			ent crop		
and participation	marked o	To Be	James Phillips						Mcn		,			
Maryland 21215-0036 d 2 should be filled within 72 hours all the add Markel Business	\$ e. 8		19a. Informant's Name/Relationship (1			Mailing Addre	ess (Street and Num	nber or Rura	l Route Number	City or To		Code)		
C 7	item 27 other tr		Melvin Howard 20a. Method of Disposition	/Husban	20b. Place of D	isposition (A	p Court	- Ba	ltmor		on - City or To	own, State		
Baltimore,	2 = 5		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ar but	A í	n other place)	06/2			tmor			
Balti Permit.	Important: eny injury once.		21. Signature of Funeral Service Licen					cility	Funero	1 50	Mico			
a & &	E & B		23a. Part1. Enter the disease, or com	Su	\mathcal{O}	410	and Address Fac h 1 C. Fac VOYE E	oad t	saltime	ne h	1D 212			
760, te be executed III	ettending physicien and ledical for use as the burial-transit	cal Ex	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of	. (g Cance	<i>"</i>				Apcroximate infer all Between Onlet and Death		
Records, P.O. Box 68 The law requires that the death certificat	ned by the ettending pl detached for use as t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	Fetal death	3 □Ectopio 5 □ Other				23d.	Date of delive Month	ery Day Year		
S, P	5 6	by Pt	Part II. Other significant conditions o	ontributing to death bu	t not resulting in t	he underlyin	g cause given in Pai	rt I.				ne cause of death?		
Records,	been si	eted								es 2 N		ably 4 Unknown		
Rec Fe ga	has 9e 2	Completed							24a. Was a autops perform	n 2 y ned?	prior to condeath?	psy findings available impletion of cause of		
	ector, pag	BeC	25. Was case referred to medical examine 2				26. Pla	ace of Death	1 ☐ Yes 2 Check only on	e)	1 🗆 Yes	2D,No		
of V	this ce al direc	ဥ	1 Yes 2 No	Hospital: 1 Inpatier			and the second second		ne Reside			y)		
Vision of Vita	tor: Alter this certific the funeral director,	tlon:	27. Manner of Death 15. latural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Tin Inju		28c. Injury at Work? 1 ☐ Yes 2	_ 30	28d. Describe ho	ow injury oc	ccurred			
Division of	Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm				28f. Location (St		umber or Rura	al Route Number,		
io late	of bell	Cert	4 Homicide	building, etc	. (Эрөспу)			-	City or Towr	, State)				
Hospi	To the Funerel Direct completely filled in by	Medicai	29a. Certifier Certifying Ph (Check only 2 Madical Examone)	ysician: To the best on ninar: On the basis of and manner sta	examination and/	death occurr or investigati	ed at the time, date on, in my opinion, d	and place, a death occurre	and due to the ca ed at the time, da	ause(s) and ate and pla	d manner as si ce, and due to	tated. the cause(s)		
To the	To the I	Me	29b. Signature and title of certifier	1 /			29c. License numbe	er ,	2	9d. Datejsi	gned (Moñ)h,	Day, Year)		
			Dielme L.	HUSLI			D368	314		6/8	22/X	6		
	10		30 Name and address of person who	completed cau a	ath (Item 23a) (T	ype, Print)	Dr. Su	ite:	302-	Tom	son 1.	ns 217d		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Areal	· · · · · · · · · · · · · · · · · · ·	.,,		, 000				
	Registr	ar	JUN 2 6 21	JUU JELLA	~ ~ ~ /	and the same								

Michelle Lynn Hoffman

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental I

yland / Department of Health and Mental Hygiene		000
Certificate of Death	Rea No	200

		1- For State Registrar	Certificate of Death						Reg. No	. 4	JU	o ZUUL	
Physicia dical Exami	an/	1. Decedent's Name (First, Mid Michelle	Lynn H	offm.			,	Month June	June 19, 2006 1248 hrs				
		4a. Facility Name (if not instituted Upper Chesapeake	Medical Center			4b. City, Town, Bel Air		Death		lc. County of Harford	Death		
Funeral Director		5. Social Security Number 2 5-78-0 67 Usual Residence of Decedent	6. Sex	7. Age (In yrs. la	ast birthday) 38 Yrs	If Under 1 Y Months D	ear If Under ays Hours	24Hrs. 8. Date	of Birth (MN	NDD/YYYY) 967	Foreign	place (State or htry) MARY LAND	
. Maryland ir 28a-f show any ied at once.	Director	10a. State 10b. Count 10c. Street and Number	0	Ea	Town or Locat					tizen of Wha	at Countr	10d. Inside City Limits 1 Yes 2 No	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f show ratic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2	Married Armed F 1 Yes Ves Very Armed F 1 Yes Very Armed F Very Arm	cedent Ever in U. forces? 2 No ar	If Y	s Decedent of les, specify Cult	Hispanic Originan, Mexican, No specify: pation (Give ki	n? (Specify Yes of Puerto Rican, etc ind of work done use retired)	Specify: White, etc. Specify: White 16b. Kind of Business/Industry			ite dustry	
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examines.	Be Completed	17 Father's Name (First, Midd			Ho	usewi	18.Mother's	Name (First, Mid	ldle, Maide		est —-	70	
e, MD 212 1 and 2 should b Health and Meni item 27 is marl	To	RANDY HOFF	nship (Typ., Print) MAN (Hu.		230	1 SNO	reet and Numb	per or Rural Route Edgew	Number,	City or Town	210	40	
Baltimore, permit Pages I at Department of Her Important: If ite injury or other tr			Specify:	rom State	Place of Dispos crematory or other rden s	PAIT	4	6 26 06	, B		MI	D	
Physician Departing Import Imp	23a/Part I. Englishe disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										0. 3	Approximate Interval Between Onset and	
Examiner	er	Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as b. Due to (or as	a consequence o	f):	anne int	OXICATIO	on				Death	
ecuted and transit	al Examiner	g g											
Box 68760, re death certificate be executed re attending physician and red for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 V L	the 1 Live 4 Preg	outcome of pregr birth nant at time of de nown	nancy 2 Fe	tal death her (Specify)	3 Ectopic	pregnancy	2:	3d. Date of d Month	lelivery Da	y Year	
Records, P.O. The law requires that the cate has been signed by page 2 should be detach	Completed by P	Part II. Other significant cond	litions contributing	to death but not re	esulting in the u	underlying caus	e given in Par	24a		No 3	Probal	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No	
tal Rection: The certificate ector, page	Be	25. Was case referred to medi examiner?	Cal Hospital:					Check only one)					
f Vita Physicia or this cer	2	1 Yes 2 No 27. Manner of Death	<u> </u>		ER/Outpatient			Nursing Home		lence 6	Other:		
_ = ^ ≥ l	Certification:	1 Natural 5 Pe	ending Fnd 6,	e of Injury th, Day, Year) 19/2006 ce of Injury - At he	28b. Time of I	3 pm 1	Yes 2 x	No unk		jury occurre		J Davita Muselhara Ciba	
Division ospital or Attenchours after death uneral Director:		4 Homicide de	termined (Specify	Found	at resid	lence		Edgewo	ood, ML)		Il Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only Certifying	Physician: To the be xaminer: On the basis and manner	of examination a		tion, in my opin	ion, death occ		date and p	lace, and du	e to the	cause(s)	
	4	high	, mo				ense number C.M.E.			ne 21, 20		h, Day, Year)	
		30. Name and address of pers Ling Li, MD Assis	on who completed car tant Medical Exa			et, Baltimore	e, M D 2120)1					
S Regis	tate trar	44444		gistrar's Signatu		rels)		-					

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ORIGINAL

	_	1- For State of Maryland / Department of Health and Mental H	lygiene 006	20003
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Month	Death Day Year	3. Time of Death
/Medic	al .	Doris Irma Inderdohnen June	19 2006	11:54 AM
Examine	er		4c. County of Dea	
	14.5°	Montgomery County Hospital Olney	Montg	
Funeral				rthplace (State or Foreign country)
Director	-	Usual Residence of Decedent	23, 1915 W	isconsin
/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
the Marylar 28a-f show	ţ	Maryland Montgomery Silver Spring		1 ☐ Yes 2- No
or 288	rec	10e. Street and Number 10f. Zip Code	10g. Citizen of What C	ountry?
036 vors after death with the Maryle at', or items 23s or 28s-1 shore Examinet must be notified at	Funeral Directo	1709 White Oak Drive 20910	US.	A
deal	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am	
atter or its	E.	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	Black, Whi	te, etc.
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or itams 23e or 28e-f show unafte event, the Medical Exemples must be notified at	d by	3 Matwidowed 4 Divorced Year or Dates:	V	vnite
15- 10- 10-	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	s/Industry
within 12	mc	Elementary/Secondary (0-12) College (1-4or 5+) SaleS	Retu	:1
d 2 Hygi	Ö	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		
ld be entat	To Be	Alfred Schaus Clara	Shacf	
laryland 212 2 should be filed with and Mental Hygiene, is marked other than aumatic avent, Inal	Η.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num		Zip Code)
Ind 2 alth a alth a 27 is		John Inderdohnen/Son 1709 White Oak Drive Silver S	ipring MD	20910
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or any injury or other traumatic avant, the Modical Exemples.		20b. Place of Disposition Date cemetery, crematory or other place)	20c. Location - City or	Town, State
Page Page nent c		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry June 20, 2000	· Hanover	MD
Baltimo		21. Signature of runeral Service Licensee 22. Name and Address of Facility Aportomy	Gifts Reasts	V
D C C C C C C C C C C C C C C C C C C C		7522 Connelley Drive south	'. Hanover, r	1D 21076
	Ical Examiner			Onset and Death
Vision of Vital Records, P.O. Box 68 Attanding Physician: The law requires that the death certific r death. actor: After this certificate has been signed by the ettending pl by the tuneral director, page 2 should be detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	23d. Date of de Month	olivery Day Year
Division of Vital Records, F or Attanding Physician: The law requires tha after death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be de	Completed by P	Pair II. Other significant conditions continuously to death out not resulting in the underlying cause given in Part I.	id tobacco use contribute t ☐ Yes 2 ☐ No 3 ☐ P	
Pec e law has b	du	Dementia 24a. W	itopsy prior to	utopsy findings available completion of cause of
Vital Resident The Tector, page				s 2 No
f Vita	Be			
Of Phys	T.	1 Tyes 2 Tyes 2 Types 1 Types 2 Types	esidence 6 Other (Spe be how injury occurred	ecify)
On Of oding Ph th.	tlon	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ No	70 How injury occurred	
Oivisio or Attendi after death. Diractor: A	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location	n (Street and Number or R	tural Route Number,
# P # # E	Certification: To	4 Thomicide determined building, etc. (Specify)	Town, State)	
Hospi 4 hou Funer Funer	edical	29a Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge death occurred at the time data and place and directly and manner stated.	he cause(s) and manner a ne, date and place, and du	e stated. e to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mon	th, Day, Year)
		1 2 PHYSICIAN 163168	1 /23/0	6
16		30. Name to a dress of proon who completed cause of death (Item 23a) (Type, Print)	MD Zana	7
17		Dr. Shyam Parkhie 1810/ Prince Philip Drive # 332 Olney, 1	10 2085	ゴ
Sta Registra	100			

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Baltimore, Maryland 21215-0036

Bennit, Pages 1 and 2 should be filled within 72 hours after death with the Mary

			For State	or Print in Black In of Maryland / Depa	artment of He	alth and Me	•	_	2nnni.		
	Physici /Medic		Registration of Item #20b Per 1. Decedent's Name (First, Middle, Last) Michael Johnso	<u></u>		2	June 2	Day Year 3rd 200			
) 	Examir Funeral	ner	4a. Facility Name (If not institution, give street and Good Scancer Ltc He 5. Social Security Number 6. Sex 1 XM 2 1	7. Age (In yrs. last birthday)		kmore	Date of Birth	4c. County of Death 9. Birth Cou	nplace (State or Foreign intry)		
Maryland	or 28a-1 ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Lo			12/04/142	1-9 ALI	10d. Inside City Limits 1 ☐ Yes 🕉 No		
ath with the	nust be noted	Funeral Director	100. Street and Number 1315 Silverthorne		10f. Zip Code 2123	1		10g. Citizen of What Country?			
bours after de	tural', or Item al Examinar I	þ	1 Never Married 2 Married 1 Yes, 3 Midowed 4 Divorced Year	Forces? Is 27 No Give r Dates:		Specity:			ACK		
at yild filed within 72 hours after death with the Maryland	lygiene. her than "nat nt, the Medic	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg 17. Father's Name (First, Middle, Last)	(Give life. I	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of working		Food Se			
Sebould be fi	and Mental H Is marked of aumatic ever	To Be	DAVID BROWN 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street an	0	PAMP be Poute Number, City	or Town, State, Zi			
Pages 1 and	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehov any Injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 Agurial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	om State 20b. Place of Dispo		rk 07/01	20c.	O・U23 Location - City or T ATIMOVE	own, State		
Daillillo	Depertrange in the property and Injury Injur		21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee	at caused the death. Do not ent	. Name and Address 905 YORK er the mode of dying	ROAD. BI	Ar mon				
3	hysician Medical xaminer	y.	Immediate Cause (Final disease or condition resulting in death)	n each line. Sepsis Gror to (or as a consequence of):		rmonia	,		Interval Between Onset and Death		
ficate be executed		dicai Examiner	Sequentially list conditions, Tarry, leading to form ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Physician: The law requires that the death certificate	within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year		
requires that	been signed be	b	Part II. Other significant conditions contributing to	o death but not resulting in the ur	nderlying cause given	in Part I.		use contribute to t			
ital net	ortificete has l	Be Completed	25. Was case referred to medical examiner?		2	6. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 A	prior to co	opsy findings available ompletion of cause of 2 No		
ending Physic	eath. or: After this ce he funeral dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (M 2 ☐ Accident investigation	Inpatient 2 FR/Outpatien te of Injury onth, Day Year) 28b. Time of Injury	28c. Injury a Work?	4 1 Mulsing Home	5 Residence . Describe how in		(y)		
spital or Att	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ai Certification:	29a. Certifier 1 Certifying Physician: To	ace of Injury - At home, farm, stre ilding, etc. (Specify)	occurred at the time	date and place and	City or Town, Sta	s) and manner as s	tatad		
To the Ho	within 24 r To the Fu completely	Medical	one) and m	anner stated.	restigation, in my opin	ion, death occurred	at the time, date a	nd place, and due to	o the cause(s)		
	Sta		30. Name and address of person who completed of INDRANI MUN. 31. Date filed (Month, Day, Year)	Heyse of death (Hem 23a) (Type, 130 CHER SEE	Print) Sam	aritan	Hospita	al Bal. 21239	timore		
	Registr	rar	JUN 2 6 2006 50	100 10 17							

DHMH 17 Rev 1/2001

			1 _ State	State of Maryland		nt of Health and te of Death		_ / UUU	20005
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Rachel H 4a. Facility Name (If not institution, give s	John S.	on.	, Town, or Location of Deat	June 3	Day Year 2006 4c. County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 220 - 14-7220	TENERAL HO 7. Age (In yrs. Ia	ast birthday) If Und Yrs. Months	or 1 Year If Under 24 Hrs Days Hours Min.		NA B. Birthpl Pount 1910 NA	lace (State or Foreign try) ryland
	death with the Maryland ms 23a or 28a-f ahow rust be notified at	Irector	Mary and Number	10c. City	3altin	Ore p Code	10g.	Citizen of What Count	od. Inside City Limits 1
36	72 hours after death wi 'naturel', or Items 23a (dical Exerciner count b	oy Funeral D	11. Marital Status 1 Never Married 2 Married 3 Noticed	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. 13. Was Dec If Yes, sp	2/2/6 adent of Hispanic Origin? (S ecrity Cuban, Mexican, Puer 20(No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
21215-0036	nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan ortent of Heelth and Mental Hygiene. ortent: if item 27 is marked other than "natural", or items 23a or 28a-f ahow injury or other traumatic avant, the Madical Examinet must be notified at its	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	rking 16b	. Kind of Business/Ind	ustry
Maryland	should be fit nd Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Andrew 19a. Informant's Name/Relationship (Type) McClasses	00 Ce	19b. Mailing Addres	Rac	me (First, Middle, Maid Le Le L		Code)
Baltimore, Ma	Peges 1 and 2 nent of Heelth a Int: If item 27 is Iry or other trau		MS Sharon B 20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pla	ace of Disposition (Nametery, crematory or	ame of	10001	Balto Location - City or Tov	111a, 4200
Balti	permit. Pege Depertment Important: If any injury or		21. Signature of Funeral Service License	7. Kuss	Joseph 2222	Ind Address of Facility L. RUSS F W. North Av	uneral H	ome, P. A., Md. 2121	Approximate
	Physician /Medical Examiner		shdof, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	Ceret	pellar I	rubarc	7	Interval Between Onset and Death
8760,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
P.O. Box 68	he death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of deliver Month	ry Day Year
	n requires thet the been signed by should be detact	ρ	Part II. Other significant conditions conf	inbuting to death but not resul	Iting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the	_/
ital Rec	iiclan: The law r certificate hes be rector, page 2 sh	Be Completed	25 Was case relerred to medical	in lati	00	26 Place of De	24a. Was an autopsy performed 1 Yes 2 3 ath (Check only one)	? prior to com death?	osy findings available inpletion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	၉	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 3 0 0 28b. Time of Injury M	Other	lome 5 Residence 28d. Describe how in)
Divis	pital or Attendurs after death arei Director: filled in by the	I Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)			City or Town, St		
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	Medical	(Check only 2 Medical Examin 29b. Signature and title of certifier	ician: To the best of my know er: On the basis of examinati and manner stated.	on and/or investigatio	o at the time, date and place n, in my opinion, death occu	irred at the time, date a	and place, and due to Date signed (Month, D	the cause(s) Day, Year)
,	3		30. Name and address of person in a con	npleted cause of death (Item	23a) (Type, Print)	94223		6.23-0	16 Hants
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 6 200	32. Pagistrar's Signati	M Rosell)	ndiauCI	O ELJEIO (, 10y,1a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTFM#5 PFR FH C856 6/26/06 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2006 **Physician** June 17, Stanley 6:58 p M Robert Jordan, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2013 Bear Ridge Road Apt. 2 Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 5, 1943 5. Social Security 0374 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
New York **Funeral** 1 XM 2 F 065-36-8314 63 Yrs. Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 3√☐ No Directo Marvland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a or 2013 Bear Ridge Road Apt. 2 21222 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after I TYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ 3 Widowed 4 Divorced 'natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) year United States Navy Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Stanley Robert Jordan, Sr. Regina Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If Item 27 Is any Injury or other trau 2013 Bear Ridge Road Apt. 2 Dundalk, MD 21222 Mrs. Saundra Jordan (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 7/26/2005 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland Part. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 23a. Part. Enter th Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma **Physician** 6 netrotation 13 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2XNo 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 27 No this certificate has 1 Yes 1 Yes 2 0 Division of Vital Be 25. Was case referred to medical 26. Place of Death Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homscide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI> 038409 the completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 5-11 Harlis Shartma # 415 (Tree 110 Md 2109 3 12753 William 31. Date filed (Month Par Year 6 32 Hegistrats Signature 2006

Registrar DHMH 17 Rev 1/2001 AMEND ITEM#5.15.20a b.c&22.perFH.C857.7/27/06.WS
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75	1	For State Registrar Decedent's Name (First, Middle, Last		,G856, <i>ც</i> გ	rifficate	or Deat		. Date of Dea	-	100	3. Time of Dea	
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Medical caminer seral ector	4	a. Facility-Name (If not institution, give	PKINS HOS	f i fall yrs. last birthday 5 Yrs.	JA /-	Year If Undo	er 24 Hrs. 8	Date of Birth (Month, Day	4c. Coun	ty of Death		
	_	Isual Residence of Decedent 0a. State 10b. County	10	c. City, Town or L								
or are		0a. State 10b. County	10	Baltimo					10d. Inside City Limi			
ect	5	0e. Street and Number		Darcimo	10f. Zip C	ode			10g. Citizen o	What Cour		
I Di	2	1007 N. Central	Avenue		1000	212	02			SA	,	
event, the Madical Examinating state barndiffed at Be Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	r in U.S. 13.	Was Deceder If Yes, specify			fy Yes or No- can, etc.)	14. Ri Bi	ace - Americ ack, White, ify: b1		
e Medical.	-	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	edent's Usual (e kind of work DO NOT use	doné during m retired)	ost of working		16b. Kind of		,	
So E		12th — 6— 7. Father's Name (First, Middle, Last)	0	ass	embly 1		ther's Name (i	First Middle		ingho	use	
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other traumatic event, ItaM To Be Comp		19a. Informant's Name/Relationship (7)	rpe, Print)	19b_Mail	ling Address (S					n, State, Zip	Code)	
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or other to	2	0a. Method of Disposition	2	20b. Place of Disp	osition (Name ematory or othe	of !	Dat	0	20c. Location	- City or To	THE RESERVE TO THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	
ry or		14 Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State	MT. CARM	EL CEM.	•	7-18-		DUNDAL			
any injury once.	1	21. Signature of Funeral Service Licens	71	CO1 3	22. Name and A tate Ar altimor	racomy	Board	CH F.H BALTIM	EAST	101 0°2120	NORTH	
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cian		mmediate Cause (Final disease or condition	1 ALVINGE	Al Par	OFE			1.8		1)	month	
lical		resulting in death)	Due to (or as a co	onsequence of):	ICCL						1.10.1111	
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6 8	בי בי	art II. Other significant conditions co	ntributing to death but no	ot resulting in the i	underlying cau	se given in Par	t I.				ne cause of dea	
should	3 -							-				
page 2								24a. Was a autops perfor 1 Yes	sy med?	prior to cor death? 1 Yes	psy findings ava mpletion of caus 2 No	
director, pag Fo Be Co	3	5. Was case referred to medical examiner?	Hospital:			Othor	ice of Death (-				
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ne funera		1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	nar) Injury	М	Work? 1 ☐ Yes 2 [on injury cook			
completely filled in by the funers Medical Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, si Specify)	treet, factory, o	office	28	f. Location (S City or Town		ber or Rura	l Route Number	
pletely fill			sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or in								
Me		9b. Signature and title of certifier			29c. L	icense numbe	r	2	9d. Date sign	ed (Month, I	Day, Year)	
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		1 down	www.		1	06062	0,0	_	-			
	3	10. Name and address of person who c	ompleted cause of death	(Item 23a) (Type		- 0	A 11.	11/2-1-	March	1 7	1769	

		For State	State of Man	yland / Dep	artme	nt of H		_		006	20008
1000 1000	100	Registrar 1. Decedent's Name (First, Middle, La	st)		Timou	10 01 1	204111	2. Date of De		•	3. Time of Death
Physic		Jean	Ε.		T.	ewis		Month June	21	2006	9;45 P M
/Medi Exami		4a. Facility Name (If not institution, given					Location of Dea			County of Death	
LAGITII	20	4801 East Hoffm	an Street		Bal	Ltimo	re			N	ΙA
Funeral		5. Social Security Number 6. S	Sex 7. Age (1	In yrs. last birthday) If Unde	r 1 Year	If Under 24 Hr		th Voar	9. Birth	place (State or Foreign
Director		214-56-6784 Usual Residence of Decedent	1 M 2 F	96 Yrs.	Months	Days	Hours Mir	Dec. 25	190	09 Vir	ginia
ylan how		10a. State 10b. County	11	0c. City, Town or L	ocation						10d. Inside City Limits
Ma-1 s	ctoi	Maryland NA		Baltimo	re						1 ☐ Yes 2 ☐ No
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tems	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Deci	edent of Hi ecify Cuba	ispanic Origin? (In, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	-	 Race - Amer Black, White 	
36 safte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No ff Yes, Give		1 🗆 Yes	2 X No	Specify:			Specify: TTL	440
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21215-0036 d within 72 hours af giene. r then "natural; or the Medical Exam	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	e kind of w	ork done o	during most of w	rorking	100. K	ind of Business/i	naustry
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cate be executed Cate be executed Physicien and Street be and	lical Examiner	23a. Part1. Inter the disease, or conshock, tr heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Defecto (or as a conductor) Due to (or as a conductor)	consequence of):	ner me mo	de or dynn	g, such as calui	ac or respiratory a	riest,		Approximate Interval Between Onset and Death 2 WEGS
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Records, P. he law requires that the law been signed by age 2 should be deta	<u>چ</u>	Part II. Other significant conditions	contributing to death but r	not resulting in the (underlying	cause givi	en in Part I.	23e. Did t		,	the cause of death?
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of Vital Physician: 1 rthis certificet ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		_	0#		eath Check only c	one)		
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Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai Ce	(Check only 2 Medical Exa	hysician: To the best of r miner: On the basis of ex	camination and/or in	ith occurre	d at the tim	ne, date and pla	ce, and due to the curred at the time,	cause(s)	and manner as	stated. to the cause(s)
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T wit		29b. Signature and title of certifier	1 1	Air	1.0						
^		Jumpa 4	tagar.	MU		062	032		JUN	E 22	2006
7		30. Na he and address of person who	completed cause of deal	th (Item 23a) (Type	, Print)	_ (0.00	0.			12-1
34 - 3 - 3		31. Date filed (Month, Day, Year)	HI >>US	Signature -		en	CIRCLE	BALLIMO	X	, MO Z	1627
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State of Maryland / Department of Health and Mental Hygiene

non D. Millorii			tificate of Death	Reg I	_{vo} 2006 2000
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Da	3. Time of Death
eulcai Exaini	1161	Darick D. Mitchiner 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 20, 200	4c. County of Death
		Franklin Square Hospital	Rosedale		Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 216.90.3006 1 M 2 F	ast birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	``	MM/DD/YYYY) 9 Birthplace (State or Foreign Country) MD
any	Ì	10a. State 10b. County 10c. City,	Town or Location	<u></u>	10d. Inside City Limits
Maryland 28a-f show any d at once.	ě	110	Ssex		1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland that of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	I Director	703 W. Kingsway	10f. Zip Code 21220		Citizen of What Country? USA
er death wi	Funeral	11. Marital Status 1 Never Married 2 Married 4 Divorced If Yes, Give Year	S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: Black
ours aft atural"	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Dccupation (Give kind of		b. Kind of Business/Industry
5-0036 led within 72 hc Hygiene, other than "na the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th avade N/A	during most of working life. DO NOT use ret		Hair Care
215-0C be filed win ntal Hygien rked other ent, the M	Be Co	17. Father's Name (First, Middle, Last) Rux Mitchiner	Nova	First, Middle, Maid Sparr	,
i, MD 2121 and 2 should be fi ealth and Mental I ten 27 is marked traumatic event,	2	19a. Informant's Name/Relationship (Type, Print) Monue He Mitchiner/Wife	19b. Mailing Address (Street and Number or 1703 W. Kingsway	Rural Route Number	, City or Town, State, Zip Code)
Baltimore, Normit Pages I and Department of Health Important: If item nighty or other trans		20a. Method of Disposition 20b. F Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cernetery, crematory or other place)		Dc. Location - City or Town, State Baltimore MD
Baltimor permit Pages Department of Important: If		24 Signature of Funeral Service Licensee 150 Clato M01363	22, Name and Address of Fadility	Funera	1 Senicos
Physician		23a. Part I. Enter the disease, or complications that caused the death.	. Do not enter the mode of dying, such as cardiac of	or respiratory arrest,	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive at Due to (or as a consequence of	herosclerotic cardiovascular	disease	8etween Onset and Death
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	f):		
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760, icate be exphysician the burial	Medical	X UNPENDED AMENDED item#23a IF FEMALE: 23c. If yes, outcome of pregi	a,27,prME,g857,7/26/06 TT		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal death 3 Ectopic pregna	ancy	Month Day Year
O. Be at the d by the stached	y Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
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Sion vttendi death. ctor: /	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		·
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide Could not be determined (Specify)	ome, farm, street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, City
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination a and manner stated.		at the time, date and	place, and due to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year)
		30. Name and address of person who completed hause of death (Item Theodore King MD. Assistant Medical Examine			
<u>_</u>	tate	31. Date filed (Month, Day, Year) 32. Resiltrar's Signatu			
Regis		11111 0000	It specks		
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			For State Registrar	State of Ma		d / Dep		of H	ealth a				•	20010
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	/Medio	al	Donald Wayne Ma. 4a. Facility Name (If not institution, give				4b. City, 1	own, or	Location of	f Death	June	21	2006 County of Death	
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	Funeral			PRAL OF E	(In yrs	last birthday, Yrs.	If Under Months	Year_ Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bin (Month, Da NOV • 9 , 1	in	9. Birth	place (State or Foreign intry)
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	anylan show del	_	10a. State 10b. County			y, Town or L	ocation							10d. Inside City Limits
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36	2 should be filed within 72 hours after deeth with the Maryland and Mantal Hygiene. Is marked other then "naturel", or Iteme 23s or 28s-f ehow summetic event, the Medical Examination and be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)		1□Yes 2		Specify:				Specify:	ite
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200 000 000 000 000 000 000 000 000 000	filed v Hygie other t		17. Father's Name (First, Middle, Last)			Crane	Opera		18. Mother	r's Name	(First, Middle,		tructic	n
lan	uld be Aental rked o	To Be	Raymond Malatt								rinkle			
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Vita	slcien certific rector	o Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only o			
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	the Hospl in 24 hou the Funer ipletely fill	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of e and manner state	ıxamına	wledge, deat tion and/or in	h occurred a	Ltha time n my opi	e, date and inion, death	place, ar h occurred	nd due to the o	cause(s) a date and p	ind manner as solace, and due to	stated. to the cause(s)
	To To	2	29b. Signature and title of certifier	-			29c.	License	number	1		29d. Date	signed (Month,	Dey, Year)
	α		30. Name and address of person who	completed cause of the	ath (Item	23a) /Tuno	Print)	25	1/3	6	1	Jur	e al	2006
	1		Dr. Kam Lum R.	Auyeran	g P	1.0.9	000 F	ank	Lins	Da ua	re Dr	ive	Baltin	oce.MD2123
	Sta Registr		31. Date filed (Month Day, Year)	2006 32 Admistrar	's Signa	ture	pour	,		V			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2006 2006 Ocre, MD2123°

		-	For State Registrar	State of Ma	ryland /		ment of H icate of L			giene Rag. No.	2006	20011
	Physici		1. Decedent's Name (First, Middle, Las		_				2. Date of De	Day	200 Year	3. Time of Death
	Physicia /Medic	al -	GEORGE ALBERT		Jr.				June	22,	2006	8:45 P.M
	Examin	er	4a. Facility Name (If not institution, give			4b		Location of Dea	ıth		County of Death	
	Consumi		Presbyterian Home		and (In yrs. last b	irthday) If	Under 1 Year	SON If Under 24 Hr	s. 8. Date of Birt	h	Baltimo 9. Birth	place (State or Foreign
и	Funeral Director			XM 2□F	79	Yrs. Mo	onths Days	Hours Min	Nov. 2	$\overset{\text{y. }}{1}\overset{\text{Year}}{1}$	6 Wash	ington D.C.
	D .	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	um or Locatio						10d. Inside City Limits
	aryla •hov	5				nervil						1 ☐ Yes 2 No
	the N	ect	Maryland Baltin	nore	Luci		Of, Zip Code			10a. Citiz	en of What Cou	intry?
	3a or	Funeral Director	13 Westbury Road	1				1093			U.S.A.	
	ms 2	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was			Specify Yes or No irto Rican, etc.)	- 1	4. Race - Ameri Black, White	ican Indian,
9	or ite	Fu	1 Never Married 2 Married	1∭Yes 2 □ N	O		s, specily cuba Yes 2⊠ No	Specify:	into mican, etc.)	j	Specify:	
215-0036	72 hours after deeth with the Maryland Insturat; or Items 23e or 28e-f ehow diget Exactinatination collited at	d by	3 X Widowed 4 □ Divorced	Year or Dates: V		2 Donadoni'	s Usual Occupa	ation			Wh:	ite
-5	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give kind	of work done of NOT use retired	luring most of w	orking	TOD. KIII	d of Business/ii	loustry
212	d with giene.	EO	Elementary/Secondary (0-12)	College (1-4or 5- 2 years		nior	Vice Pr	cesident		Bar	nking	
pu	al Hy d othe	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle,			
yla	ould t Ment sarke sarke	6	George Albert My						n Mills	Far		
Maryland	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship (Karen L. Myers Za	**					Rural Route Number			·
ē,	Heel Heel tem 2		20a. Method of Disposition	curici (carage	20b. Place	of Dispositio	n (Name of	!	Date		ation - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heeth and Mental Hygiene. Department of Heeth and Mental Hygiene. Important: If Item 27 is marked other than *natural; or Items 23a or 28a-f show any rightry or other traumatic event, It a Medical Examinar must be notified at ance.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific				ry or other plac Cremat		-24-06	Bal	timore.	Maryland
alti	partm porta y inju		21. Signature of Funeral Service Licer	see	1							
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell—Wiedelele Seorge J. Cerrarse 23. Name and Address of Facility Mitchell—Wiedelele 6500 York Road										e, M	aryland	21212
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin-	Θ.				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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of Vital Records,	w require been si should t	Completed				-						
Rec	e la hes je 2	dш				·				osy rmed?	death?	opsy findings available ompletion of cause of
ta	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical					26 Place of D	1 Yes		1 □ Yes	2 No
25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther. 4 Nursing Home 5 Residence 6 Other (Specify)										ify)		
25. Was case referred to medical examiner? 1 Yes 2 S No 25. Was case referred to medical examiner? 1 Yes 2 S No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other work? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at work? 28. Place of Death (Check only one) 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 3 Suicide 6 Could not be determined betarmined betarmined betarmined betarmined to the property of the could not be determined betarmined betarmined betarmined betarmined by the could not be determined betarmined by the could not be determined									occurred			
sio	Mtsndin death. ctor: Afi y the fur	catic	2 Accident investigation 3 Suicide 6 Could not b	1			M 1 🗆	Yes 2 No			· · · · · · · · · · · · · · · · · · ·	
Division	or At efter of Direction by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	tarm, street,	factory, office		281. Location (l Number or Rui	ral Route Number,
_	Hospitei 4 hours e Funers!!		29a. Certifier 1 Certifying Pt	ysician: To the best of	f my knowled	ge, death oc	curred at the tin	ne, date and place	ce, and due to the	cause(s)	and manner as	stated.
	To the Hospitel or Attsm within 24 hours efter deat To the Funeral Director: completely filled in by the	edical		ninar: On the basis of and manner sta	examination a							
	Within To th	M	29b. Signature and title of certifier	146	11	nn	29c. Licens				signed (Month	
			> U	- Atten	- mg		U.	1016		74	re ds,	2006
	12		30. Name and address of person who Continue in the Market of the Market of the Month, Plan Year) 6	completed cause of de	eath (Item 23a	(Type, Prin	(harles	54,54	te 4105	5.	Hum	4:212 Bm
8	Sta	te	31. Date filed (Month, Play, Year)	2006 32. Pegistra	r's Signatur	ha	ands)	- 17				
100	Regist		JUN 2 6	ZUUO A	per so	P	C. Bulle					

		For State Registrar	State of Maryland		ment of H			giene 200	6 20012
Physicia /Medica Examine	al .	1. Decedent's Name (First, Middle, Last) A 10 VSI US 4a. Facility Name (If not institution, give str	W Ma-lon	41		Location of Death	2. Date of Dea Month	Day Yea AD AD 4c. County of D	eath A M
Funeral Director	KI.	5. Social Security Number 6. Sex 18-18-4392	7. Age (In yrs. last	t birthday) II	f Under 1 Year Months Days		8. Date of Birt (Month, Day Oct. 3		Birthplace (State or Foreign Country) Wyland
with the Maryland a or 28e-1 ehow	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		fown or Locati	Par	kville			10d. Inside City Limits 1 ☐ Yes 2√ No
ath with the 23s or 2	Funeral Directo	10e. Street and Number 8810 Walther Blvd	•		10f. Zip Code	21234		10g. Citizen of What U.S.	•
Ours after death	þ	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes. Give Year or Dates: WW 11		s Decedent of Hi es, specify Cuba Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	
Daltimore, Maryjand ZIZIS-0050 semit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If tem 27 1s marked other then "natural", or its any injury or other traumatic event, the Madical Examinance.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind life. DO	NOT use retired	during most of work		16b. Kind of Busine Baltimor Public S	e City
2 should be filed wi and Mental Hygien is marked other th aumatic event, In.	To Be C	17. Father's Name (First, Middle, Last) Francis Malone				18. Mother's Nam	e (First, Middle, Strain	Maiden Sumame) 187	
nd 2 should alth and Mer 27 is marke	1	19a. Informant's Name/Relationship (Type Mrs. Irma C. Malone				and Number or Rui Blvd., Pa		ar, City or Town, State	
Pages 1 and ent of Healt nt: If Itam 2 ry or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	noval nom State		on (Name of ory or other plac CMATONY		Date / 2006	20c. Location - City Baltimore	or Town, State Maryland
permit. Pages 'Department of the Important: If Its eny injury or ot once.		21. Signature of Funeral Service Licensee		22. N	ame and Addres	ss of Facility Sc	himunek	Funeral H	omes
Physician /Medical Examiner as the prival-transit as the prival-transit	edical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, heading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequent of the consequent of	nce of):	Con u		or respiratory ar	rest,	Approximate Interval Between Onset and Death
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quires that en signed b ruld be deta	þ	Part II. Other significant conditions contr	abuting to death but not resulting	ng in the unde	erlying cause give	en in Part I.	23e. Did to	~1	o to the cause of death? Probably 4 □Unknown
n: The law requicete has been r, page 2 should	Completed							osy prior rmed? death	autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
Attending Physician: The law requires that the death certificete be executed or death. •ctor: Atter this certificete has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit.	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home	Bb. Time of Injury		4 Nursing H	ome 5 ☐ Residence Page 1 Residence Page 28d. Describe Page 28f. Location (S	dence 6 Other (S	pecify) Rural Route Number,
To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificete has been signe completely filled in by the funeral director, page 2 should be deather.	dical Cert	29a. Certifier 1 V Certifying Physic	building, etc. (Specify) cian: To the best of my knowle ir. On the basis of examination	edge, death oc	ocurred at the tim	ne, date and place,	and due to the	cause(s) and manner	as stated.
To the H within 24 To the F complete	Medi	29b. Signature and little of certifier	and manner stated.		29c. License			29d. Date signed (Mo	onth, Day, Year)
Stat	te	31. Date filed (Month, Day, Year)		2 Walt	her Blu	d., Parki	ville, M	D 21234	
Registra	ar	JUN 2 6 2006	Street S.						

Please Type or Print in Black Indelible Ink

manda Rene M	1	ns State of Maryland / Department of Health 1- For State Certificate of Death Registrar		_	g. No. 200	6 2001
Physicia Medical Examir	ın/	Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death 0708 hrs
redical Examin		Amanda Rene Mullins 4a. Facility Name (if not institution, give street and number) 4b. City, To	wn, or Location of Death	June 24, 2	4c. County of Deat	
j		4 Sharondale Way Apartment C Essex	Titu to all	L	Baltimore Co	
Funerai Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 218-80-0313 1 M 2 XF 45 Yrs. Usual Residence of Decedent		12/30/	1960	
, any	ŀ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
daryland 28a-f show 1 at once.	ğ	Maryland Baltimore Essex				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10f. Zip 0 4 Sharondale Way Apt "C" 212			g. Citizen of What Cou	ntry?
with t ms 23a be not		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	≾∠ I t of Hispanic Origin? (Spe Cuban, Mexican, Puerto F	ecify Yes or No-	U. S. A. 14. Race - Amer White, etc.	rican Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	3 Widowed 4 Divorced or Dates:	No specify:		Specify: W	hite
2 hours after "natural", I Examiner			ccupation (Give kind of wo ing life. DO NOT use retire		16b. Kind of Business	Industry
5-0036 lled within 7 Hygiene. I other than the Medica	Completed	12 Beautician	1		Salon	
r filed all Hyging of the	Be Co	17. Father's Name (First, Middle, Last) Trvin Mullins	18.Mother's Name ((First, Middle, M — Clay	aiden Surname)	
2121 hould be find Mental is marked ttic event,			(Street and Number or Ru		per, City or Town, State	e, Zip Code)
and 2 sl and 2 sl ealth ar rem 27 traums	-	Charles Ross Mullins (Brother) 1924 Flois 20a Method of Disposition (Name	e Lane Edge	ewood,	Maryland 2 20c. Location - City of	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Cremat	cory 6/	26 06	Baltimore	, Maryland
Bal permi Depar Impo		21 Signature of Funeral Service Licensee 22 Name and A Bruzdzi 1407 0	oddress of Facility Inski Funera Id Eastern A	l Home ;	PA Essex Mar	yland 21221
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical इxaminer		Immediate Cause (Final disease or condition resulting in death) Bronchopneumonia Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
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60, ate be ex hysician ie burial	edic	item#23a,27,perME, G858	, 8/10/06 TT		22d Date of delices	
ox 68760, eath certificate be executed attending physician and for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnar	ncy	23d. Date of deliver Month	y Day Year
Box 687: death certification attending ped for use as the	ysici	4 Pregnant at time of death 5 Other (Special Yes 2 No 9 ✓ Unknown 9 Unknown	fy)		V.	
P.O. Be es that the de igned by the be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.		pacco use contribute to	
IS, P.C quires that en signed l	ted b			1 Yes	2 No 3 Pro	bably 4 Unknown
cords t law requi	Completed			autops perfor	prior to death?	completion of cause of
tal Rec certificate ector, page			6.Place of Death (Check o	1 Yes 2	No 1 Y	es 2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC		g Home 5f	Residence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No		ow injury occurred	
Divis Hospital or A 24 hours after Funeral Direc	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, (Specify)	office building, etc.	28f. Location (S or Town, St		ural Route Number, City
To the Hos within 24 h To the Fun	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tome one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred at		and place, and due to t	he cause(s)
	Ž		O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)
		30. Name and suddess of person who completed cause of death (Item 23a)				<u> </u>
		22 Printer Circulus	eet, Baltimore, MD 2	21201 		
Si Regis	tate trar	ILINIO O 2000				
DHMH 17 Rev 1/2	2001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 04 ERNEST MOORE /Medical Facility Name (If not institution, give street and number) 4c. County of Death Gity, Town, or Location of Death Examiner MORE N/A 5. Social Security Number 6. Sex 1 M 2 ☐ F tf Under 1 fear If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 93 Director 1912 SOUTH CAROLINA 248-18-2640 NOV. 10 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits then "naturaf", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 TXYes 2 □ No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2027 DIVISION STREET 21217 U.S.A. be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XX es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2XXVo Specify: BLACK Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other there any Injury or other traumatic event, the Mangany Injury or other traumatic event, the Mangany. 3rd grade REALITOR/WELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown MAGGIE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2630 Thornhill Rd., Huntsville, Alabama 35810 Lollie Stoner/Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LOUDON PARK CEMETERY 06-27-06 BALTIMORE, MARYLAND 21. Signature of Funer \S 22. Name and Address of Facility WILLIAM C BROWN COM 1206 W NORTH AVENUE COMMUNITY FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final Dyb to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of): Examiner Hospital or Attending Physicion: The law requires thet the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 DInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the Hospital or Attentoring within 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hour who completed cause of death (Itemi23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		artment of H		ental Hygie	4000	20015
	Physicia		1. Decedent's Name (First, Middle, Last) MARGARE	- M,	A.R.T	YN		2. Date of Death Month	Day Year 21 200	3. Time of Death 7:10 P.M
6	/Medic Examin		4a. Fecility Name (If not institution, give s St. Martin's Hor			4b. City, Town, or	Location of Death	70702	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 577–36–6583	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You April 19,	ear) 9. Bir	thplace (State or Foreign puntry) hington D.C.
	anyland show	or.	Usual Residence of Decedent 10a. State 10b. County Maryland Baltime		ty. Town or Lo	nsville				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the M or 28e-f	Director	Maryland Baltime	ore	Cato	10f. Zip Code		10g	. Citizen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show amy injury or other treumetic event, it a Mardical Evant act must be recitied at ADRG.	by Funeral	601 Maiden Choice 11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	Lane 2. Was Decedent Ever in UAmed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		21228 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No-	USA 14. Race - Am Black, Whi Specify: Wh	te, etc.
21215-0036	within 72 hou ene. then "natura	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, tered Nur	luring most of workir)	ng	b. Kind of Business	/Industry
Maryland 2	uld be filed Mental Hygi rked other itic event, 1	To Be Co	17. Father's Name (First, Middle, Last) Elroy Plant		Regio		18. Mother's Name Magdalene	(First, Middle, Ma.	iden Sumame)	
, Mary	and 2 sho ealth and h n 27 Is me		19a. Informant's Name/Relationship (Ty) Joan E. Holmes	Daughter	1135	Ridge Ro	and Number or Rura ad; Getty	sburg, P	ennsylvan	ia 17325
altimore,	Pages 1 tment of He tent: If iter		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State Me	cemetery, crer adowric		Park 6/24	/2006 1		Maryland
Ba	permil Depar Impor any in		21. Sign wire Funer S License 23a. Part1. Enter the disease, or compli			2. Name and Address ineral Hot 530 Edmond	ne of Cato lson Avenu	rling Ast onsville, ue; Cator	thon Schward Inc. Insville, I	ab Witzke
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	. Myp ca	rdia	e In Industry	farct			Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consect. Due to (or as a consect.						
8760,	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
	ath certiff ttending or use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	w requires that the de: been signed by the a should be detached f		Part II. Other significant conditions con		_	nderlying cause give	en in Part I.			o the cause of death?
Il Records,	ıysiclen: The law re iis certificate has ber director, page 2 sho	Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vita	rsiclen s certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	☐ ER/Outpatier	nt 3 DOA Othe	26. Place of Death		⇔ 6 □Other (Spe	scitu)
Division of Vital	nding Phy ath. r: After thi e funeral o	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work		28d. Describe how		ony
Divis	iel or Atte s after des al Director ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Ath building, etc. (Spec		reet, lactory, office	2	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Examination)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owiedge, deat ation and/or in	vestigation, in my op	oinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
	į	2	29b. Signature and title of confifier	erau		29c. License	1649	Ju 29d	NE 22	th, Day, Year) 2006
	У		30. Name and address of person who co	7, 3455	m 23a) (Type, - W. R.	Print) KRNS /	we SA	LTUNDA	et M	2006
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 6 2006	a. Registrar's Sign	Apa	W				

			For State Registrar	tate of Maryland / Dep <i>Ce</i>	eartment of Health a		giene 006	20016
	Physici		1. Decedent's Name (First, Middle, Last) Phyllis Elizabeth M	loynahan		2. Date of Dea Month	Day Year	3. Time of Death 9:20 A. M
	/Medic Examin		4a. Facility Name (If not institution, give stree 905 Windsor Road	et and number)	4b. City, Town, or Location Pikesville	of Death	4c. County of Dea	
	Funeral Director		5. Social Security Number 020-01-3517 Usual Residence of Decedent	7. Age (In yrs. last birthday 2 Tark 87	If Under 1 Year If Under Months Days Hours	8. Date of Birth (Month, Day Dec. 16,	r, Year) Co	thplace (State or Foreign puntry) sachusetts
	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimore	10c. City, Town or L Pikesvil				10d. Inside City Limits
	or 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	s 23c		905 Windsor Road	W 5 4 4 5 1 110 1 100	21208		USA 14. Race - Ame	dan tadin
980	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. 27 is marked other than "natural", or Items 23c or 28a-f show traumatic event, the Medical Eventies must be notified at	by Funeral	1 Never Married 2 Married	Mas Decedent Ever in U.S. Armed Forces? I □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 ☐ Yes 2 ☒ No Specify:	n, Puerto Rican, etc.)	Black, Whit	
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade continued in the secondary (0-12) 12	mpleted) (Giv College (1-4or 5+)	edent's Usual Occupation e kind of work done during mos DO NOT use retired) Omemaker	st of working	16b. Kind of Business Own Ho	
d 2	illed Hygid other ent,	Be Co	17. Father's Name (First, Middle, Last)	Ω		er's Name (First, Middle,		owe
/lan	should be ind Mental s marked o umatic eve	To B	Edward Gosselin		Eli	zabeth Bess	ette	
Man	l 2 sho h and l r is ma		19a. Informant's Name/Relationship (Type, Information of the Thomas J. Moynahan,	~ 0501	ling Address (Street and Number D			Zip Code)
	1 an Heal em 2		20a. Method of Disposition	20b. Place of Disp	position (Name of	Date Date	20c. Location - City or	Town, State
o E	Pages nent of int: If It		1 XBurial 2 ☐ Cremation 3 ☐ Remo 1 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	ematory or other place) dge Cemetery	6/27/2006	Pikesville,	Marvland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign of a funeral Service Lea	locale "	P22. Name and Address of Facili Funeral Home of 1630 Edmondson	Sterling As of Catonsvil Avenue; Ca	hton Schwal le, Inc tonsville,	Witzke
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death. Do not erause on each line. Black Due to (or as a consequence of):	nter the mode of dying, such as ? ANCCL	cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions b.	200 10 (01 23 2 00135430105 01).				,
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
68760,	ficate be e physiciar s the buri	dical	d					
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and a page 2 should be detached for use as the burial-transit.	hysiclan/Me	in the past 12 months?		□ Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributions	uting to death but not resulting in the	underlying cause given in Part l	I. 23e. Did to	obacco use contribute to res 2 No 3 □ Pr	o the cause of death?
I Record		Completed				24a. Was autop perfor	an 24b. Were at prior to death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	nital:	Other	e of Death (Check only o		
of	ing After une	ation: To	To res 23 No	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at		lence 6 Other (Spe	ecify)
Division	i ji ji d	Certification:	3 Suicide 6 Could not be 4 Homicide determined 2	8e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical		en: To the best of my knowledge, dea On the basis of examination and/or and manner stated.	investigation, in my opinion, dea	ath occurred at the time, o	date and place, and due	e to the cause(s)
	To t To 1	Σ	29b. Signature and title of certifier for the family for	imley MD	29c. License number		Jun 23,	
	10		30. Name and address of person who completely the transfer of the second	ey 400 (07	MAVE	Beltmar	e MD	21210
5	Sta Regist		31. Date filed (Month, Day, Year) 6 200	6 /32. Registrar's Signature	goods)			

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	State of Maryland / Department of Health and Mental Hygien []	5
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			1 - For State Registrar	State of Mil		rtificate of			leg. No.	20017
	Physici	an	1. Decedent's Name (First, Middle					2. Date of Dea Month		3. Time of Death
	/Medic		Gertrude Murra					June	19, 2006 Year	5:30 AM
	Examin	er	4a. Facility Name (If not institution 5858 Bellanca	•		4b. City, Town, o	r Location of Death .dge		4c. County of Death Howard	
	Funeral Director		5. Social Security Number 143–10–4128	6. Sex 7. Ag	e (In yrs. last birthday, 94 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day March 1		place (State or Foreign intry) V Jersey
	nyland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			1	10d. Inside City Limits
	88a-1 s	Director	Maryland Howard	i	Elkrid					1 □ Yes 2 ₩ No
	3s or 3	i Dir	5858 Bellanca	Drive		10f. Zip Code 210	75	1	10g. Citizen of What Cour USA	ntry?
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar mast be mullined at once.	Funeral	11. Marital Status 1 Never Married 2 Mari	12. Was Decedent Armed Forces? 1 □ Yes 2 🔯 If Yes, Give		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 ② No	tispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	***	
3	hours tural',	ed by	3 X Widowed 4 □ Divorced	Year or Dates:	163 Door	dent's Usual Occur				
2	thin 72 e. an "nat	Completed		t's Education st grade completed) College (1-4or 5	(Give	e kind of work done DO NOT use retired	during most of work d)	ing	16b. Kind of Business/In-	dustry
V	filed withIn Hygiene. ether than "	Co	12	(and	1	Homemaker		(Fina 66) day	Own Home	2
yland	uld be fi Aental F rked ot tic ever	To Be	17. Father's Name (First, Middle, Thomas W. Lade				18. Mother's Name Anna M.		Maiden Sumame)	
ary	2 should have and have and		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number	r, City or Town, State, Zip	Code)
ອ໌ ອ໌	1 and Health em 27 ther tr		Mary Jean Pari	cott Daugh	ter 5858 20b. Place of Disp			lkridge	MD 21075 20c. Location - City or To	num State
Saitimor	ages ant of I it: If Ito y or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cre	matory or other plac	ce)		Elkridge, Ma	
	partme partme cortar / Injur		21. Signature of Funeral Service		1 // 2	2. Name and Addre	ss of Facility Ste	rling As	shton Schwab	
ם	89558		Kema	Mal	verter	runeral H 1630 Edmo	ome of Ca	tonsvil	topovillo N	m 21228
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aeach li	ne.	ter the mode of dyir	0	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner			HVa	a consequence of):	-	./2			
	B V =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to or as	a consequence of					
	certificate be executed rding physician and the set the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
00/00	ysicial	Medicail		d.						
_	= 0,0	_	IF FEMALE:	00- 14						
. DO	death e atter	hysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _			23d. Date of delive Month	ery Day Year
Ų,	requires that the een signed by th nould be detache	by Ph	Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	ınderlying cause gıv	en in Part I.		bacco use contribute to the	
COLCE	redu	eted						1 🗆 Ye		
Ū	The lavate has	Completed	<u> </u>					24a. Was a autops perfort	sy prior to cor	psy findings available mpletion of cause of 2 No
VIII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		ot 3C DOA Oth	26. Place of Death			
ō	y Phys ar this eral di	n: To	1 Yes No 27. Manner of Death	28a. Date of Inju		III JUDON	4 Nuising Ho		ence 6 Other (Specify ow injury occurred	y)
SION	Attending I ir death. ector: After by the funer	ation	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	y Year) Injury		k? Yes 2 □No			
DIVISION	tal or Att rs after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of Inj building, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (St City or Town	treet and Number or Rura n, State)	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tir evestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, d	ause(s) and manner as st ate and place, and due to	lated. the cause(s)
	To t To t	Ž	29b. Signature and title of certific			29c. Licens	e number	2	9d. Date signed (Month, 6)	
	3	1	30. Name and ad less of person	who completed cause of d		Print) N. Roll.	ny RD	Bart	OMOZI	286
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	K)				
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DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylan		artment of H rtificate of L			giene 2005	20018
33	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Noble				2. Date of Dea Month	21 Day 2006	
) 	Examir Funeral	er	4a. Facility Name (If not institution, give the Harbor Hosp 5. Social Security Number 6. September 6. Septemb	7. Age (In yrs.	iast birthday)	4b. City, Town, or Baltim If Under 1 Year	ore /	S. 8. Date of Birth	4c. County of Dea	thplace (State or Foreign
9 0	Director		Usual Residence of Decedent	M 2□F 84	Yrs.	Months Days	Hours Mir	Oct.28,		vland
e Maryiar	la-f show	ctor	Maryland Baltimore		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with th	3a or 26	i Director	10e. Street and Number 717 Maiden Choice	Lane ST 217		10f. Zip Code 21228		1	Og. Citizen of What Co USA	ountry?
d 21215-0036 ilied within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: if iteme 23s or 28s-f show importent: if item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Madicial Examiner must be notified at once.	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 → No	Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: U	se, etc. SA
21215-0036 d within 72 hours af	jiene. r than "nat the Madici	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wo	orking	16b. Kind of Business	•
Maryland of the could be filed	Mental Hyg sarked othe satic event,	To Be C	17. Father's Name (First, Middle, Last) James F. Noble		-		18. Mother's Na	me (First, Middle, Bunting	,	
Jore, Mar ages 1 and 2 sh	nt of Health and : If item 27 le π · or other traum		19a. Informant's Name/Relationship (Ty, Mary Nobl.e Wi 20a. Method of Disposition 1 28 Burial 2 Cremation 3 R	fe 20h P	717 M	-	ice Lan	e ST 217;	20c. Location - City or	1e,MD 21228 Town, State
Baltimore,	Departmer Importent eny injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Purperal Service License	Eas	tern S F	hore . Name and Addres: uneral Ho	s of FacilitySt me of C	erling As	Hurlock, Ma shton Schwa e, Inc. consville,	b Witzke
/ //	physician and Medical summer summer transit	dicai Examiner	23a. Part1. Enter the disease, or conclishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of): Om nuence of):	er the mode of dying	, such as cardia	aton lav	mbert di	Approximate Interval Between
Records, P.O. Box 68 The law requires that the death certifica	ed by the ettending ph detached for use as th	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of dei Month	ivery Day Year
rds, P.	5 8	by	Part II. Other significant conditions con	stributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.		bacco use contribute to	the cause of death?
	n. Atter this certificate has been si funeral director, page 2 should	Completed							ned? prior to death?	atopsy findings available completion of cause of
ysicis	is cert direct	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatien	Otho	r	ath <i>(Check only on</i> Home 5□ Reside	ence 6 □Other (Spec	cr(fv)
Division of Vita To the Hospital or Attending Physician:	death. tor: After thi the funeral	Certification: 1	27. Manner of Death 1 Natural 5 Pending envestigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. fnjury Work			ow infury occurred	
DIVI:	hours after deatl unerel Director; ly filled in by the		3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	v) 			City or Towr		
the Hosp	within 24 hours after of To the Funerel Direct completely filled in by	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my op	inion, death occ	urred at the time, da	ate and place, and due	to the cause(s)
, L	<u>×</u> 5 8		29b. Signature and title of certifier	>		RE License		1	9d. Date signed (Month	**
15.	+1		30. Name and address of person who co	1	23a) (Type,	Print) 300 Ski	Ab Haus	Duer Street	1. Baltimore	2006 MD, 21225
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa		andi)	-		, , , , , , , , , , , , , , , , , , , ,	

		1	For State Registrar		State o	f Marylar		irtment of	f Health ai of Death	nd Ment		jiene Jeg. No.	06	20019
	Physicia		Decedent's Name (First, M.	ddle, Last)		17				N	ate of Dea Ionth	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institu	ition, give si	reet and nu			4b. City, Tow	n, or Location of		6		2006 ty of Death	
•	Examin	ler	Manor Care	_					Catonsvi					imore
	Funeral Director		5. Social Security Number 216-28-0019	6. Sex	м 2 Х F	7. Age (In yrs 74	. last birthday) Yrs.	If Under 1 Ye Months Da		Min (f	ate of Birth Nonth, Day	(Year)	Cou	place (State or Foreign ntry) ryland
-	D.		Usual Residence of Deceden			100 C	ity, Town or Lo	cation						10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be mailfied at	2	MD 10b. Cou	altim	ore	100.0	, .	onsvil]	e					1 ☐ Yes 2 X No
	the M	Director	10e. Street and Number					10f. Zip Coo				10g. Citizen o	f What Cou	intry?
	with t		296 Bloomsbu	rv Ro	ad. Ar	ot. 9		2	21228			United	l Stat	es
	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Modical Examination at	d by Funeral	11. Marital Status 1 Never Married 2X 3 Widowed 4 Divor	Married ced	2. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	edent Ever in lorces? 2 X No		fYes, specify 0 1 ☐ Yes 2 X 0		jin? (Specify , Puerto Ricar	Yes or No- n, etc.)	Spec		, etc. Vhite
9500-6121	within 72 h ene. than "natu he Medical	Completed	(Specify only hi		completed)	1-4or 5+)	(Give	dent's Usual Od kind of work do DO NOT use re Omemake	one during most htired)	of working		16b. Kind of	Own I	
N	filed w Hygier other th		10 17. Father's Name (First, Mid	dle, Last)				ОЩСШАК		r's Name <i>(Fir</i>	st, Middle.	Maiden Suma		ТОШС
\subseteq		o Be	Edward Strin						Ann	a Yess	ler			
ary	should I ind Meni s marke umatic	-	19a. Informant's Name/Relat		oe, Print)		19b. Mailir	ng Address (St	reet and Number	r or Rural Ro	ute Numbe	er, City or Tow	m, State, Zi	ip Code)
മ്	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		George R. 01 20a Method of Disposition X Burial 2 Cremal 4 Donation 5 Othe	ion 3□R		20b. State MD	296 B Place of Dispo Vecera Crownsv	nsition (Name of matory Cellic Ins Cellic	tery	Date		atonsvi 20c. Location Crownsv	n - City or T	
Baltı	permit. Departm Importal any inju	(21. Funeral Ser	V/ S		Della	2873	Name and A	ohur Spr	ing Rd	., A	rbutus,		21227
	Physician /Medical Examiner	<u>.</u>	23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	e, or compli List only or	Due to	each line.	equence of):		DEME			1631,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		;	o (or as a conse								
P.O. Box 6	The law requires that the death certific ate has been signed by the attending P page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	It	1 🗀 Live	utcome of preg birth 2 Fe gnant at time of nown	tal death 3[⊒Ectopic pregr ⊒ Other (specn					Date of deli Month	very Day Year
	uires that signed by Id be deta	d by Ph	Part II. Other significant co						e given in Part I.	_				the cause of death?
Division of Vital Records,		Complete									24a. Was autor perfo	osy irmed?	prior to death?	topsy findings available completion of cause of 2 \(\text{\substitute}\) No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to me examiner?		Hospital:				Othor	of Death (C)				
of	S S	L.	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 L	Inpatient 2 e of Injury	☐ ER/Outpatie		4 UZ NU			dence 6 00		cify)
ision	al or Attending Ph s after death. Il Director: After th id in by the funeral	Certification;	1 Natural 5 P 2 Accident in 3 Suicide 6 0	ending vestigation ould not be	(Mo	onth, Day Year)		М	Injury at Work? 1 Yes 2 I		Location (Street and Nu	mber or Ru	ral Route Number,
Οİ	To the Hospital or A within 24 hours after To the Funeral Directorphetely filled in by		4 Homicide	etermined	buil	Iding, etc. (Spe	rnowledge dea	th occurred at t	he time, date an	nd place, and	City or Too	cause(s) and	manner as	stated.
	e Fun	Medical	(Check only 2 Me	dical Exami	ner: On the	basis of exam anner stated.	ination and/or i	nvestigation, in	my opinion, dea	ath occurred a	t the time,	date and plac	ce, and due	to the cause(s)
	To th within To th сощр	Me	29b. Signature and title of c	ertifier					icense number			29d. Date sig		
	6		> V-v	mD				D	00591	7.0		06	- 21-	2506
1	2		30. Name and address of po		ompleted ca	use of death (I	tem 23a) (Type	Print)	VE RE	1598	· ブンWA	- m	0 411	136
	S Regis	tate trar	31. Date filed (Month, Day,	Year) 6 200	6	Registrar's Signal	gnature	and	VE RE					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2 Date of Death nt's Name (First, Middle, Last) 3. Time of Death Month **Physician** 22:05 M 2006 JUNG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SAMARITAN TOSPITAL ALTIMORE Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign **Funeral** Days Hours 10M 20F 735-72-0334 Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe or iteme 23a or Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or item eny injury or other traumatic event, the Madical Examinations. 1 Never Married 2 Married Yes 2 No 1 Yes 20 No Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) y/60 en gry (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 MD 2/239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 26/00 ☐ Burial 2 ☐ Cremation 3 Removal from State Farrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ull Balto MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart faifure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) Acute hypercarbic respiratory **Physician** /Medical Due to (or as a consequence of) Examiner stage End rena disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No the Hospitel or Attending Physician: tor: After this certific the funeral director, Be 25. Was case referred to medical 26. Pface of Death Check only one Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Infury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie -, m.D. 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 560/ Loch Spert GAATTINO APARNA TONNA Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 6 State 2006 Registrar

_			For State Registrar	State of Ma		Depa		lealth and	Mental Hy	giene Reg. No. 2	006 20	021
	Physici /Medio		Decedent's Name (First, Middle, Last) Dorothy Helena Pet	tie					2. Date of De Month	Day	Year 3. Time	of Death
	Examir Funeral Director		5. Social Security Number 6. Sex	spital C	enter (In yrs. last)	birthday) Yrs.	4b. City, Town, of Post Control of Control o	T Location of Dea	S. 8. Date of Bi	th ay, Year)	9. Birthplace (State Country) Maryland	or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	9	10c. City, To	own or Loc SSEX	ation				10d. Inside 1 ☐ Ye	City Limits
	death with the Maryland ma 23s or 28s-f ehow rmust be notified at	al Director	10e. Street and Number 810 Glass Avenue				10f. Zip Code 2122	1		10g. Citizen	of What Country?	
036	urs after death with the Manylan al', or Itema 23a or 28a-1 ehow Examicer mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:			das Decedent of H Yes, specify Cub	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.))- 14. F E Spe	Race - American Indian, Black, White, etc. cify: White	
1213-0036	filed within 72 hours after Hygiene. ther than "natural", or Ite int, It's Modical Examina	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	Sa. Decede (Give k life. D	ent's Usual Occup ind of work done O NOT use retire HOUSEWI	pation during most of widd) fe	orking		Business/Industry	
ryland 2	2 4 5 5	To Be C	17. Father's Name (First, Middle, Last) Kenneth William G	rant	,			18. Mother's Na Marga	_{ame (First, Middle} ret Mar	. Maiden Sum y Marx	name)	
Mary	12 a = a		19a. Informant's Name/Relationship (Type Tammy Lee Pettie (I								wn, State, Zip Code) land 21236	
Baltimore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ceme	tery, crem	ition (Name of atory or other pla Cemetery	1 - 1 -	Date 5/2006		on · City or Town, State Ore, Maryla	and
Balt	permit. Pege Department of Important: If eny injury or once.		21. Signature of Funeral Service License	muske		Bı	Name and Addre UZdzins 107 Old	ki Funer	al Home Avenue E	P.A. ssex, l	Maryland 21	221
8760, <	Physician Medical Examiner Medical Examiner Physician and as the privial-transit	dical Examiner	23a./Paf1. Enter the disease, or complic pooks, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e. a consequence s + a + t consequence	Tan se of): (C	ne mosor dyn ne re or	le	ac or respiratory a	iresi,	Approxim Interval B Onset and	etween
.O. Box 6	that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 1 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		1	Date of delivery Month Day	Year
rds, P.	w requires that it been signed by should be detac	ed by Ph	Part II. Other significant conditions con Septic Shock	tributing to death bu	it not resulting	g in the un-	derlying cause giv	ven in Part I.	-	obacco use c	ontribute to the cause of	
al Reco	ysician: The law requisis certificete hes been director, page 2 should	Completed by							1 Yes	psy prmed? 2 X No	b. Were autopsy finding prior to completion of death? 1 Yes 2 No	s available cause of
Division of Vital Records, P.O. Box 68	ng Ph fter th ineral	ation; To Be	27. Manner of Deat 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 28t	Outpatient Time of Injury	3 DOA Ott	er: 4 🗌 Nursing	Home 5 Resi	dence 6 □(
Divis	To the Hospital or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc		farm, stre	et, factory, office		28f. Location (City or To		mber or Rural Route Nu	mber.
	the Hosp hin 24 hou the Funal npletely fil	Medical	(Check only 2 Medical Examinone)	ician: To the best of ier: On the basis of and manner sta	examination	dge, death and/or inve	estigation, in my o	ppinion, death occ	e, and due to the curred at the time.	date and place	e, and due to the cause	
	5 N S S	-	29b. Signature and title of certifier	13		,	29c. Licens	0055	79/	Zad. Date sig	ned (Month, Day, Year)	
	15		90 Name and address of person who could be seen and address of person address of person and address of person address of per	hers 70			oste Di	Ba/1	sinore,	1/d 2	1237	
	Sta Regista		JUN 2 6 2	006	r's Signature	J. 19						

		-	For State Registrar	State of Mary		artment of I		nd Mental Hy	giene Reg. No. 006	20022
	Physicia		1. Decedent's Name (First, Middle, Last) Naomi G. Porter					2. Date of De Month June 2	Day Year	3. Time of Death 3:58 P M
	/Medic Examin		4a. Facility Name (If not institution, give str IVY Hall Geriatric			4b. City, Town, o Middle			4c. County of De Balti	ath
	Funeral Director		213 10 3030	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir (Month, Da Oct. 2,	th y, Year) 9. B 1912 Ma	irthplace (State or Foreign Country) ryland
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the had or 28e-1	Direct	10e. Street and Number 2164 Coralthorn Rd.		MIGGIE I	10f. Zip Code 21220			10g. Citizen of What 0	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show amy orlents: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other traumatic event, Ite Maralcal Examiner must be notified at ODGE.	by Funeral Director		. Was Decedent Ever Armed Forces? 1			Hispanic Origin an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		
21215-0036	I within 72 houliene.	Completed	15. Decedent's Educe (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retire Clerk	during most o	of working	16b. Kind of Busines Aerospa	•
Maryland 2	uld be filed Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) Harry Goodman					s Name <i>(First, Middl</i> e, e E. Walbe		
Mary	nd 2 sho Ith and It 27 Is ma		19a. Informant's Name/Relationship (Type Christel League (Fr			,			er, City or Town, State , Maryland	
Baltimore,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition 1 🗵 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	mount from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - City of Baltimore,	or Town, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licenses	lounke	2 E 1	2. Name and Addr Bruzdzins 407 Old	ki Fund Easteri	eral Home n Avenue E	P.A. ssex, Mary	land 21221
ı	Physician		23a. Pan 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	death. Do not en	ter the mode of dyi	-	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a co	pertens	in				
	te be executed ysician and ne burial-transit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co	rial F	iballa	tim			
68760,		icai	Ŭ d.	CM	amal	~ 81 mh	ns Parl	Crech	my	
P.O. Box	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	Physician/Med	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		23d. Date of d Month	elivery Day Year
	w requires that the debeen signed by the a should be detached f	by	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the u	inderlying cause gi	ven in Part I.		obacco use contribute Yes 2 No 3	to the cause of death? Probably 4 🛣 Unknown
of Vital Records,	: The faw recate has bee	Completed						24a. Was autor perfo 1 🗌 Yes	psy prior to prmed? death?	
f Vita	ding Physicien: The In. After this certificate hat funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 🗆 Inpatient	2 ER/Outpatie	nt 3 DOA Ot	han	of Death (Check only of sing Home 5 Resident	one) dence 6 Other (Sp	pecify)
ion o	Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wo	ry at ork?]Yes 2 □ No		how injury occurred	
Division	tel or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, st Specify)	reet, factory, office		28f. Location (City or To	Street and Number or i wn, State)	Rural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledicai	(Check only 2 Medical Exeminations)		amination and/or in	vestigation, in my	opinion, death	occurred at the time,	cause(s) and manner date and place, and d	ue to the cause(s)
)	To With	Σ	29b. Signature and title of certifier	- (ND	29c. Licen	31464		29d. Date signed (Mod	
_	6		30. Name and address of person who con	an Im	P21 11. F	WIAM -	it fait	£ 300 E	Pulhmus	MD 21201
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 6 200	32. Pegistrar's	Signature	barles				

			For	State of Maryland / Dep		Mental Hygier	ne	00000
			Steta Registrar	Ce	ertificate of Death	Reg. I	10. <u>2</u> U U b	3. Time of Death
н	Physicia	an	1. Decedent's Name (First, Middle, Last)	PE	RKINS	Month [Day Year 2/ 2006	1740, M
¥	/Medic		ESSIE M 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	TUNE	4c. County of Death	ICA
	Examin	er	BON SE COURS	HOSPITAL	BALTIN	nont	NIA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months Days Hours Min.		9. Birthp	lace (State or Foreign
	Director		05 -32 - 182 Usual Residence of Decedent	M 2/0 F 8 / Yrs.		May 13,1	919 Sou	th Carolina
	land		10a. State 10b. County	10c. City, Town or	Location	·	1	Od. Inside City Limits
:	Mary	to	Maryland N/A	Bal	timore			1 XYes 2 No
	th the	Directo	10e. Street and Number	4 . #.	10f. Zip Code	10g.	Citizen of What Cour	itry?
	ath wi	ral	6618 Eber	e Drive 30	2 21215		UST	t
	er de:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?1 □Yes 2 ▼No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
99	urs aft	by	3 → Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: B	acK
215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or items 23s or 28s-f ehow event, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	(Gi	cedent's Usual Occupation	nrking 16b.	Kind of Business/In	dustry
2	hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	D	dian H	CO NYC
27	illed w Hygiei ther ti	Co	17. Father's Name (First, Middle, Last)	0 110	DUSEKEEPE.T	me (First, Middle, Maid	en Sumame)	Spinic
Maryland	d be dentail	To Be	Frnect P	yrd	Dos	sie Mo	Clain	
ary	should and Men marke umatic		19a. Informant's Name/Relationship (Type	pel Print) (daughter) 196. Ma	ailing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip	Code)
	and 2 selth a n 27 ls		Ms. Greta The	umpson 166	18 Eberle D	rive 305	Batto	Md, 21215
ore	Pages 1 nent of H int: If Ites iry or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R	cemetery c	sposition (Name of prematory or other place)	-/	Location - City or To	
Baltimore,	그런 끝든 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	11/1, 2	22. Name and Address of Facility		insdou	37
Ba	Depa Impo eny I) alonk	KUM	Joseph L. Russ	uneral Ho	me, P. A.	16
			23a. Part/ Enter the disease, or complished, or heart failure. List only or	sations that eaused the death. Do not de cause on each line.			1.10.	Approximate Interval Between
\	Physician		Immediate Cause (Final disease or condition		STRUCTIVE PUZ	MONARY	DISEASE	Onset and Death
Ĺ	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		er	if any, leading to immediate	Due to (or as a consequence of):				
V	outed anslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
ó,	sate be executed physicien and the burial-transit	Exe	resulting in death) Last	Due to (or as a consequence of):				
		dlcal						
Вох 6	death certifice e attending ph d for use es t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delive	эгу
		icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.O.	res that the de signed by the a be detached f	Phys	9 Unknown			93a Pid tabasa	o use contribute to the	as source of death?
	law requires that the es been signed by th 2 should be detache	þ	Part II. Other significant conditions con	thouting to death but not resulting in the	o underlying cause given in Part I.	23e. Did tobacc		ably 4 Unknown
Records,	w require been signal	Completed		HEART FA		24a. Was an		psy findings available
Rec	9 d	dmc	CINCIC	176 1719 FM	TLUME	autopsy performed	prior to co death?	npletion of cause of
tal	sicien: T certificat rector, pa	Be C	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 ☐ eath (Check only one)	NO IL TES	21,540
<u></u>	× 5	To B	examiner? 1 Yes 2 Mo	lospital: 1 Diffipatient 2 ER/Outpat	tient 3 DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Specif	y)
0 0	ing Ph		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	y Work?	28d. Describe how in	njury occurred	
Division of Vital	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f. Location (Street	and Number or Rura	I Route Number
Ď	al or A efter I Direct d in by	Certification:	4 Homicide determined	building, etc. (Specify)	Stroot, ractory, office	City or Town, St		
	To the Hospital or Atlending I within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer			sician: To the best of my knowledge, dener: On the basis of examination and/or				
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
	or viii			02.	A-111-	(12/101	÷· — ,
	1		30. Name and address of person who co	impleted cause of death (Item 23a) (Tyr	D30277		101106	
	P		THOMAS S.	million 1	ON SECOURS 1	HOSPITAL	BACTIN	wort, MD
	Sta Regist	ate	31. Date filed (Month, Day, Year) JUN 2 6 200	MICLEN 19 329Registrar's Signature	books			

	1 - State Registrar		·	Departme <i>Certifica</i>			R	eg. No.	5 2002
	1. Decedent's Name (First, Middle,	Last)					2. Date of Dear	th Day Ye	3. Time of Death
hysician Medical		Irene Ro	ose Perry					9, 2006	6:45 P
kaminer	4a. Facility Name (If not institution,	give street and num	nber)	4b. City	, Town, or Loca	ation of Death		4c. County of D	
	Stella Maris Ho	spice Cer	nter		Towson	1		Balti	more Co.
eral	5. Social Security Number 6		7. Age (In yrs. last bi	Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Forei Country)
tor	216-74-0905	1 ☐ M 2 💢 F	94	Yrs.			Sept. 6		Maryland
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	m or Location					10d. Inside City Limi
	,		Too. Oity, 100	III OI LOCATION					1 ☐ Yes 2 ☑ N
Director	Maryland Bal	timore		1	Carne	У		0.00	
/ Funeral Director	10e. Street and Number			10f. Z	ip Code			0g. Citizen of Wha	
펼					21 23			United S	
Funeral	11. Marital Status	Armed For		13. Was Dec If Yes, sp	edent of Hispan ecify Cuban, M	exican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
by Fi	1 Never Married 2 Marrie	If Yes, Giv	0	1 ☐ Yes	2√2 No Sp	ecify:		Specify:	
		Year or Da		December 11	.10		1725	10h Kind of Dono	White
Completed	15. Decedent's (Specify only highest	grade completed)	168	i. Decedent's Us (Give kind of w life. DO NOT	ual Occupation ork done during	most of work	ng	16b. Kind of Busin	ess/industry
dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)					O II	
ပိ		et)		HOU	sewife	Mother's Name	(First Middle	OWN H Maiden Sumame)	ome
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other treumatic	19a. Informant's Name/Relationshi			-				r, City or Town, Sta Marylan	
	Mr. Ralph Perry	(,							
50	20a. Method of Disposition 1X□ Burial 2 □ Cremation 3	□Removal from S	cometa	of Disposition (N ery, crematory or	other place)	l I		20c. Location - City	y or Town, State
Suce	4 □ Donation 5 □ Other (Spe			Lawn Cem	etery	6/2	2/2006	Baltimo	re, Maryland
once	21. Signat Le of Funeral Service Li	censee		22. Name :	and Address of	Facility Peral Ho	ome of I	undalk,	Inc.
8	West a la	27.0					lalk, Ma		21222
	23. Fart1. Enter the dis e, or c shock, or heart fill re. List o	omplications that can't one cause on ea	aused the death. Do	not enter the me	ode of dying, su	ch as cardiac o	or respiratory arr	est,	Approximate Interval Between
ın	Immediate Cause (Final	.,	Diamer	1					Onset and Death
ai	disease or condition resulting in death)	Due to (or as a consequence	of):			·		y ears
er									
ē	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a nunsequundo	of):					
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Examiner	resulting in death) Last	Due to (or as a consequence	of):					
ca		d							
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Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy					23d. Date of	f delivery
hysicial	in the past 12 months?		irth 2 □Fetal deat ant at time of death	h 3 □Ectopic 5 □ Other (Month	Day Year
Ş	9 Unknown	9□ Unkno	wn						
흐	Part II. Other significant condition	s contributing to de	eath but not resulting	in the underlying	cause given in	Part I.	23e. Did to	bacco use contribu	te to the cause of death?
D.	Canao stur	Hea	of Fo	ilore			1 □ Y	es 2 🗖 No 3 🛭	Probably 4 Unknow
leted i							24a. Was a	24h 18/or	e autopsy findings availal
Compl	Dec placet	VIGGO	100				autop	sy prior	r to completion of cause of
ပိ	rempheran	Vascu	MUR D	72092			1 ☐ Yes		Yes 2 No
Be		Hamital				Place of Death	Check only or	76)	
ို				utpatient 3 1				ence 6 Other (Specify)
Certification:	27. Manner of Death 1⊠Natural 5 ☐ Pending		th, Day Year)	Time of Injury	28c. Injury at Work?		28d. Describe n	ow injury occurred	
cati	2 Accident investigation in a suicide 6 Could not	t bo		M	1 🗆 Yes				
Medical Certificat	4 Homicide determin	ad 286. Place	of Injury - At home, I ng, etc. <i>(Specify)</i>	arm, street, facto	ory, office		28f. Location (S City or Tow		or Rural Route Number.
		0/1							
ca	29a. Certifier 1⊠ Certifying (Check only 2 Madical E		best of my knowledg						
Medical	one)		ner stated.	The of the ostigation	an, minity opinio	.,			000 10 1110 00030(3)
Σ	29b. Signature and title of certifier	((11/	2	9c. License nui	mber		29d. Date signed (A	
	- mestiv	re W	Jught V	((N	D50	141		June	50 m 5006
	30. Name and address of person w	ho completed caus	e of death (Item 23a)	(Type, Print)					
ļ									
2	ERNESTINE WRI	GHT, M.D.	2300 DU.	LANEY VA	LLEY RO	DAD TI	MONIUM.	MD 21093	

DHMH 17 Rev 1/2001

6:45 P.M.

JUNE 19, 2006

IRENE PERRY

06-04373 Ved Parkash

Me

Please Type or Print in Black Indelible Ink Manufand / Department of Health and Mental Hygiene

Parkasn		State of Maryland / Department of Health and Mental H		eg. No.	200	6 2002					
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	th	Year	3. Time of Death					
dical Examir		Ved Parkash 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 21, 2		ounty of Death	1700 hrs					
		Johns Hokins Bayview Baltimore		,,,,							
Funeral Director		5. Social Security Number 487-56-3494 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) F 1 Vrs. F 73 Yrs. F 1 Vrs. F 1 Vr			Foreign	nplace (State or n Intry) India					
nd how any ce.		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location Maryland Wicomico Salisbury				10d. Inside City Limits 1 Yes 2 No					
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 27082 Patriot Drive 21801	1		of What Coun	try?					
r death with or items 23 must be no	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto			White, etc.	an Indian, 8lack,					
urs after tural",	2	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of			of 8usiness/lr	dian					
2 21215-0036 hould be filed within 72 hours after hot Mental Hygiene. is marked other than "natural", tric event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	tired)								
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	E O	5± Veterinarian 17. Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle,			edicine					
215 be filed ntal Hy rked o	Bec	Ram Rang Magoon Sita W	lasson								
21.3 should bend Mer is mar	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		-							
ages I and 2 shount of Health and N	-	Chander Magoon 14532 Ballyclarc Dri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date		TX /8/. ation - City or						
nore		1 8urial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory 06	/24/2006	Ba	altimor	e, Maryland					
Baltimore, bermit Pages I ar Department of Hes Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home of C 1630 Edmondson Ave	terling	Ashto	n Schw	ab Witzke					
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	enue, Ca	tońsy est, shock,	ville,	MD 21228 Approximate Interval					
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Intracranial Hemorrhage 8etween Onset and Death									
Examiner		or condition resulting in death) Due to (or as a consequence of): Hypertensive Cardiovascular Disease									
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·								
_ k(=	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									
executed an and al - transit	edical E	d. UNPENDED AMENDED									
'60, zate be ohysicia ne buniz	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	ate of delivery								
P.O. Box 68760, that the death certificate be execute ned by the attending physician and detached for use as the burial - tran	cian/	b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify)									
Box e death o the atten ed for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown									
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by inneral director, page 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		he cause of death? ably 4 Unknown							
Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been seled in by the funeral director, page 2 should the	ompleted			osy ormed?		opsy findings available ompletion of cause of					
Rectificate or, page	ပ	25 Was case referred to medical 26.Place of Death (Check	1 Yes	2 No	1 🗸 Ye	s 2 No					
Vita ysiciar this cer directe	o Be	eyaminer?	ing Home 5	Residence	6 V Other	Scene					
of Ing Pt After funeral	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury o	occurred						
Siol Attender rector: by the	icati	2 Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and I	Number or Rui	ral Route Number, City					
Division spital or Attentions after death neral Director: filled in by the	Certification	3 Suicide 6 Could not be determined (Specify)	or Town,								
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cau at the time, date	and place,	and due to the	e cause(s)					
	Σ	29b. Signature and title of certifier O.C.M.E.			e signed <i>(Mor</i> 24, 2006	nn, Day, Year)					
3		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2126	01								
St Regis	tate	11 (N. D. C. 71) (11) 11 12 12 13 14 14 14 14 14 14 14 14 14 14 14 14 14									
Regis	ueli	OUIL NO STORY OF THE PROPERTY									

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene David William Richardson Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 0802 hrs DAVID William **Medical Examiner** Kichardson June 21, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 6910 Copeleigh Road Towson 7. Age (In yrs. last birthday) 9 Birthplace (State or 5 Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Days Hours Min Country) Maryland Director 11/24 220-56-4636 55 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits IOc. City, Town or Location any 1 Yes 2 No or items 23a or 28a-f show must be notified at once. TOWSON MD hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Numbe 6910 Copeleigh U.S.A. 21212 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes White 1 Yes 2 No specify: Specify: Widowed Divorced Yes. Give Year Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pianist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baker Faye D Kichardson William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bridget D Woodbury Richardson (wife) Kavon Ave. BATIMORE, MD 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) 1 Number 2 Cremation 3 Removal from State Rockville, MD 127/06 Cemeter Donation 5 Other Specify: 22. Name and Address of Facility Greene Fining Sers 21. Signature of Funeral Service Licensee Vaughn Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line /Medical Death Carbamazepine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last requires that the death certificate be executed and Physician/Medical AMENDED item#23a,27,28a-f,perME,g857,7/28/06 TT X UNPENDED physician the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 1 Live birth Fetal death 3 Ectopic pregnancy Month Year After this certificate has been signed by the attending inneral director, page 2 should be detached for use as t 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death 26.Place of Death (Check only one) 25. Was case referred to medical funeral director. Be Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 FR/Outpatient 3 2 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 Yes 2 y No Fnd 6/21/2006 | Fnd 8:00 am within 24 hours after death To the Funeral Director: the Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State 6910 Copeleigh Road Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Found: other (scene) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number O.C.M.E. June 22, 2006 0 30. Name and address of person who comp eted cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day Year

State Registrar

6 2006

			For State Registrar	State of Ma		epartme Certifica			Mental Hy	giene	0 6	20027
E	Physici		Decedent's Name (First, Middle, Last RADET.I.E. F.	ANSEEN RIT	TEMHOUS	F.			2. Date of De Month June 2	nath Dav	Year	3. Time of Death 11:50 PM
	/Medic Examin		4a. Facility Name (If not institution, give		TOWS	ocation of Dea		4c. County		County		
	Funeral Director		5. Social Security Number 6. S 217-16-3001 Usual Residence of Decedent	ex 7. Age	88 (In yrs. last birt	hday) If Under Months		f Under 24 Hr Hours Mir		y, Year)		place (State or Foreign ntry) yland
timore, maryiand zizio-uuso	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28s-f show says injury or other traumatic event, the Medical Explainment to intellise at ODGe.	To Be Completed by Funeral Director	10a. State 10b. County	12. Was Decedent I Armed Forces? 1 Yes 2 M I Yes 2 M I Yes Give Year or Dates: ucation de completed) College (1-4or S 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	sband 1 20b. Place of cermeter.	Tow 101. Z #538 13. Was Deciff Yes, sp 1 Yes Decedent's Us (Give kind of w iffe. Do Not' Cocial W Mailing Addres 055 Wes Disposition (Na) y, crematory or Ridge (1)	adent of Hispacify Cuban, 2 No Jail Occupation of done during the done done done done done done done don	on ing most of w 3. Mother's No. Lilli d Number or F Da Road ry 6/2	ame (First, Middle Lan Se Gural Route Numb 1, Towson Date 6/2006	League Chi . Maiden Sumamieguine er, City or Town, 1, Maryla 20c. Location	(hat Cour SA - America - White, - White, - White, - State, Zip and 2 City or To	can Indian, etc. Lte dustry Crippled en Code) 1204 own, State Maryland
Division of Vital Records, P.O. Box 68/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and in proceed completely filled in by the funeral director, page 2 should be detached for use as the burial-transit in in in it.	Medicai Certification; To Be Completed by Physician/Medicai Examiner	IF FEMALE: 23c. If yes, outcome of pregnancy 1							23d. Date Monor Mo	e of delive th bute to th gradient Day Year Day Year Day Year Day Year Day Year Day 4 Unknown Day findings available mpletion of cause of 2 No Day No Day Year Day Year	
	To I with	Σ	29b. Signature and title of certifier 30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pript)	D 5	9303 6 303	3 29d. Date signed (Moni			Day, Year) 2000
	Sta Registr		31. Date filed (Month, Pay, Year) 6 2	ESMO	ar's Signature	Jacki Garle	arks	Sr 13	ANKON	e mo	2120	7

			1 - State Registrar	epartment of Health and N Certificate of Death	F	Reg. No.	20028
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Margaret A. Rohe 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June	23, 2006 4c. County of Death	10:35 A M
	Examin	er	Genesis Healthcare-Franklin Woods	Baltimore		Baltimor	e
	Funeral Director		5. Social Security Number 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day NOV. 20	h, Year) 9. Birthpla Counti	ace (State or Foreign Y) Land
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		10	d. Inside City Limits
	Maryla 1 • ho	ō	Maryland Baltimore	Baltimore			1 □Yes 2 No
	r 28a	rec	10e. Street and Number	10f. Zip Code		10g. Citizen of What Count	ry?
	23a o	ai D	8620 Kelso Drive, Apt. D407	21221		u.s.A.	
980	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene. It is marked other then "neturel", or Iteme 23e or 28e-f ehow traumatic event, the Medical Exertains could be multied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)		
2-0	72 ho	eted	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ang	16b. Kind of Business/Indi	ustry
121	within ne. hen.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	te. DO NOT use retired) I-OWNER		Restaurant	
9	e filed withing Hygiene. other there		17. Father's Name (First, Middle, Last)		e (First, Middle,	Maiden Surname)	
lan	Mental Mental Med c	To Be	George T. Deckelman	Anna Ma	vrgaret	Necker	
Maryland 21215-0036	nd 2 should alth and Men 27 is marke ir traumatic			Mailing Address (Street and Number or Rui O Winding Valley Dr			
Baltimore,	of Healt of Healt fitem 2			crematory or other place)	Date	20c. Location - City or Tov	
Ë	mit. Pages 1 partment of H portant: if ite y injury or ott		4 □Donation 5 □ Other (Specify) Garden	s of Faith Cem. 6/2	6/2006	Baltimore, M	aryland
Ball	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licensee Rineker	22. Name and Address of Facility Sc 9705 Belair Rd., B			2.5
п			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	RENAL FAIL	LURE	2	WEEKS
	Examiner		Due to (or as a consequence or)	TENSION			
		Jer	if any, leading to immediate Due to (or as a consequence of)	:			
	acuted ind transi	Examiner	that initiated events c.	TEREMIA			
,092	te be executed ysicien and ne burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of)				
68			<u>.</u>				
Box	Physician: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	y Day Year
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did to	obacco use contribute to the	e cause of death?
of Vital Records,	w requires been sign should be	ed by	PULMONARY	EMBOLUS	1 □ Y	res 2 No 3 □ Proba	bly 4 □Unknown
900	e law re has bee je 2 sho	Completed			24a. Was	an 24b. Were autop	sy lindings available apletion of cause of
Ä	an: The lifticate ha	Com			perfo	rmed? death?	28KNO
Vita	ysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Dea			
	Phys r this ral dir	. To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp 27. Manger of Death 28a. Date of Injury (Month, Day Year) Injury	atient 3 DOA 4 Exhursing H		dence 6 Other (Specify,)
ion	nding F th. :: After e funer	ation	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larn building, etc. (Specify)	n, street, factory, office	28l. Location (S City or Tox	Street and Number or Rural vn, State)	Route Number,
	Hospite 24 hours Funerel etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 1 Medical Examiner: On the basis of examination and/and manner stated.				
	To th Within To th comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, D	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (T	D40008		6 23	06
	IU		JIM PARSHALL 9105 FRANKL	0 1 0 0 - 0	BAL	TIMORE, I	MD.
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DH	Regist		JUN 2 6 2006 Bear & Special	de			
- '			OF	IGINAL			

06-04340

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Arnold B. Redmond

1- For Regis	r State Certificate of Death	Reg I	vo. 2006	2002
Physician/ 1. De	ecedent's Name (First, Middle,Last)	Date of Death Month Da	ay Year	ime of Death 218 hrs
	Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 21, 200	4c. County of Death	2101113
,	University Hospital Baltimore City		NA	
i une gi	ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	,	Foreign	ce (State or
Director 217	7 56 9736 XM 2 F 55 Yrs.	June 7,	1951 Country	MARYLAND
. 1	al Residence of Decedent State 10b. County 10c. City, Town or Location	/	10d	, Inside City Limits
<u>*</u> ,	neulan MA BOLDMON		1]	Yes 2 No
-faryland 28a-f show 1 at once.	Street and Number 10f, Zip Code	10g	Citizen of What Country?	
3a or 3	801 WABASH AUG 21215		USA	
or items 23a or 28a-f shomust be notified at once Funeral Director	Marrital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - American White, etc	ndian, Black,
fer dea	1 Yes 2 No No		Black Specify: US/A	
atural" d by	Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired.)		b. Kind of Business/Indus	try
5-0036 ed within 72 hour lygiene. he Medical Exau Completed	lementary/Secondary (0-12) College (1-4 or 5+)		Private In	Dustry
5-0036 led within 7 Hygiene. I other than the Medica Comple		(First, Middle, Maid		/
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D 21215-00: should be filed with and Mental Hygiene 7 is marked other 1 antic event, the Meromatic event	Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	-	11	
e, MD I and 2 sho Health and 2 sho item 27 is r tranmati		Ao Boi	DC Location - City or Town	2/2/6
등 교육 드린 1	Burial 2 Cremation 3 Removal from State crematory or other place)	1		
Baltimo	Donation 5 Other Specify. Signature of Funeral Service Licensee Stephology St	NYMAN	BATILION,	end Hime
Balt permit. Depart Import	Praco Alus. 5240 Registarstruck	Id B	Althour, 1	ul 2/2/
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	nediate Cause (Final disease a Multiple Injuries ondition resulting in death) Due to (or as a consequence of):			Death
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if an	uentially list conditions, The property of th			
E (Disc	sease or injury that initiated ints resulting in death). Last Due to (or as a consequence of):			
	X AMENDED item#14, perfH, 9856, 6/26/06 TT			
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68760 certificate b anding physis se as the bu	EMALE: Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery Month Day	Year
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by the deficiency by the Dart	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the c	ause of death?
P.C es that igned I be deta		1 Yes	2 No 3 Probably	4 Unknown
Records, The law require, ficate has been sign, page 2 should be Completed		24a. Was an autopsy		y findings available letion of cause of
eco he law ate has age 2 s		performe		2 No
tal R cian: 7	Was case referred to medical 26 Place of Death (Check examiner?			
F Vite	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursin	ng Home 5 Re 28d. Describe how	sidence 6 Other:	
oding oding of the control of the co		Subject fell fro		
Visio or Atter frer deat in by th	Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc.		et and Number or Rural F	toute Number, City
Division o Hospital or Attending 24 hours after death 25 Hours after death 36 Hours all Director: After 37 Hours after death 38 Hours after death 38 Hours after death 39 Hours after death 39 Hours after death 30 Hours	Suicide 6 Could not be determined (Specify) Office Building	or Town, State 103 South Gay	y Street , Baltimore	, MD
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as feedical Certification: To Be Completed by Physician	a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	I due to the cause(s) and manner as started.	150(5)
To the Ilo within 24 P To the Fu completely (cue oue) 7967	and manner stated.		9d. Date signed (Month, i	
	Det O.C.M.E.		lune 22, 2006	,
30.	Name and address of person who completed cause of death (Item 23a)			
1 1	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201		
	Date filed (Month, Dav, Year) 32. Registrar's Signature			

06-04235 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Adam Cruz-Ruiz 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day June 18, 2006 1334 hrs **Medical Examiner** Adan Cruz Ruiz Adan Cedillo Ruiz 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert 1430 Turner Road Lusby 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 11/12/1970 Country) Mexico 35 1 X M None Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 XNo -f show s 23a or 28a-f show e notified at once. Colquitt Moultrie Georgia 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Mexico 31768 1045 $J_{\bullet}D_{\bullet}$ <u>Herndon Road</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married Yes 2 X No Yes 2 No specify: Yes, Give Year Specify 3 Widowed Divorced Mexican Examiner þ or Dates 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hos trent of Health and Mental Hygene retait: If item 27 is marked other than "mai or other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) Complet Laborer Farmi no 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aurelio Cedillo paz Filemona Ruiz Zuniga ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1045 J.D. Herndon Rd., Moultrie, Georgia 31768 Angel Cedillo Ruiz, Brother 20b. Place of Disposition (Name of cemetery, Baltimore, Permit. Pages 1 and Department of Heali Important: If item injury or other tra 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) E.J. Laguna Del Monte X Burial 2 Cremation 3 X Removal from State 07/01/2006 Mexico Laguna Del Monte Other Specify Donation 5 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Rausch Funeral Home 20676 440 S. Broomes Island Ra., Port Republic, MD M01113 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wounds (2) to Torso Immediate Cause (Final disease **⊊xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit executed Physician/Medical #1 per ME g882 8/16/08 TT X AMENDED UNPENDED physician the burial Box 68760 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Þ Records, P. 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ Hospital: 1 Inpatient 2 OOA Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 After this မ 1 Yes 28a Date of Injury FOUND: 28c. Injury at Work 28d Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot FOUND: Natural 1 Yes 2 ✔ No Director: / 5 Pending - death Jun 18, 2006 1334 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1430 Turner Road, Lusby, MD within 24 hours at To the Funcral D (Specify) Mobile Home 4 / Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 19, 2006 O.C.M.E. 7 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

State Registrar

31. Date filed (Month, Day, Year)

istrar's Signature 2006

06-04331 Anthony Rheubottom

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 20031

		1- For State Registrar				$C\epsilon$	ertificate (of Dea	th				Reg. No.			0 40,00
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dical Exami			Anthôn	. T.o.o.	Dhaubat	.						Month June 21,	2006	Year	.	0130 hrs
1		4a Facility Name (Rheubot			T4b Cite	Town, or L	ocation of	Death	June 21,		c. County o	f Death	
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Funeral								der 1 Year	If Under	_	8. Date of E	Birth(MM	I/DD/YYYY)	9 Birth Foreign	hplace (State or n MD	
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any		10a. State	10b. County			10c. Cit	y, Town or Loc	ation								10d Inside City Limits
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fary 28a-	ect	10e. Street and Nu	umber					10f. Z	ip Code				10g. Cit	izen of Wh	at Coun	try?
he N I or	Director	71.8 Apr	pleton S	24					21217	•		i	US	SA		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.		11. Marital Status	precon 3	1	2. Was Dece	edent Ever in	U.S. 13. V	Vas Dece			in? (Spec	cify Yes or N			Americ	can Indian, Black,
ath v	Funeral	1 X Never Marr	ied 2 N	arried	Armed Fo	TYX:	ŀ	Yes, spe	cify Cuban,	Mexican,	Puerto R	ican, etc.)		White,	etc.	
or de	Fu	3 Widowed	4 🗆 Di	unspeed of	1 Yes Yes, Give Year	2 XX No	1	Yes	XX No	sneofic:				Specific T	. 1	
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5-0 ed w tygic othe	ပ္ပ	17. Father's Name	,	. ,					11	B.Mother's	s Name (F	First, Middle	, Maiden	Surname)		
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Sho and and is		Tillion	Tomon/	Connect			718	Apple	eton Sc	. Balt	o. M	21217				
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nore ages lant of Hi nt: If it		1 X Burial 2		n 3	Removal fro	m State	crematory or	other plac	e)	- 1					-	
Page ment tant:		4 Donation 5	Other S	Specify:			Mount Zi)6/28/		La	nsdown	e, M)
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra		21. Signature of F	uneral Servic	e License	е	•	22	. Name ar	nd Address	of Facility	Wy1	ie Fune	eral	Home P	.A.	
ii ii De Q		Sum	, la	40	mea)						,MD 212				
Physician		23a. Part I, Enter t				used the dea	th. Do not ente	r the mod	e of dying, s	uch as ca	rdiac or r	espiratory a	rrest, sh	ock, or hea	rt	Approximate Interval
/Medical		failure. List o	•	0.1		of about										Between Onset and Death
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ficate be executed g physician and stee burial - transit	n/Medical Examiner	UNPENDE	D		AMENDED											
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68760, certificate be nding physici	≩	IF FEMALE: 23b. Was deceden	t pregnant in	tho	1 Live bi	outcome of pre		Fetal deat	h 3	Ectopic	pregnanc	cv	123	Month		ay Year
certi	<u>.</u>	past 12 month	ns?	- 1		ant at time of		Other (S)			P 9. I	-,				_, ,,,,,
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endi ath.	≗	1 Natural		nding	Jun 21, 1	2006	0025 hrs		1Y	es 2 🗸	No O	abjool on	ubbcu			
isi rected	<u>:</u> 2	2 Accident		estigation	28e. Place	e of Injury - At	home, farm, s	treet, facto	ory, office bu	uilding, etc	. 2			and Numbe	r or Rur	al Route Number, City
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n 24 re Fu	한 후 등 하고 함께 다음 전에															
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			() AA	75					O.C.N	Λ.E.			Jur	ne 21, 20	006	
		30. Name and add	drass of parce	n who co	moleted care	e of death (Ite	em 23a)		······································				_l_			
2		Ana Rubio					111 Penr	Street	. Baltimo	re, MD	21201					
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	State	31. Date filed (Mo	nth, Day, Yea	2006	SE RE	gistrar's Sign	No.	ALL P								

		_	1- State of Maryland / Department of Health and Mer Certificate of Death	Reg. N	4000	20032	
	Physicia /Medic	al	Serena C. Sturdivant	06 22		3. Time of Death 2. 4SPM	
	Examin	٠,	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LOVIEN Frankford NUTSING Home BAUTIM Dre 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	. Date of Birth	lc. County of Death	slace (State or Foreign	
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	Maryland a-fabow	tor	10a. State 10b. County 10c. City, Town or Location BATIMORE		1	0d. Inside City Limits 1 ☐ Yes 2 No	
	th with the 23a or 28 at be not	ai Direc	10e. Street and Number 4704 Lochraven Bivo 21239		Citizen of What Cour	ntry?	
36	irs after dea il', or items	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rica 1 Yes 2 No Specify: 1 Yes 2 No Specify:	ty Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: BU		
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy fortury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER		16b. Kind of Business/Industry BOARD OF EDUCATION		
Maryland 2	ould be filed Mental Hygi arked other atic event, it	To Be Co		0	st, Middle, Maiden Sumame) Powell		
	end 2 sho ealth and m 27 le m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Re 309 STONE HOUSE CT. P.	PASAdenA	, MD. 2	1122	
Baltimore,	Pages 1 ment of He tant: If iten jury or oth			106 BA	Location - City or To	MD	
Bal	permit Depart Impor any in		21. Signature of Funeral Service Incensee 22. Name and Address of Facility VAME 4905 YORK ROAD · BA	ALTO, MI		,	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	espiratory arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner	-	Due to (or as a consequence of):				
Z	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.				
09/89	ficate be execu physician and is the burial-tra	Ical	a. Dysoracia with weight	thos			
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	<u>. </u>	23d. Date of delive Month	ory Day Year	
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Democratical States of the Contribution of the United States of the United Sta	23e. Did tobacco	use contribute to the	ne cause of death?	
al Reco	: The law requicate has been page 2 should	Completed		24a. Was an autopsy performed?	prior to condeath?	psy findings available inpletion of cause of	
of Vita	hysician this cedifi al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	5 Residence		1)	
Division of Vital Records,	To the Mospital or Attending Physician: The Is within 24 browns after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	1 Solution 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	d. Describe how in Location (Street: City or Town, Sta	and Number or Rura	l Route Number,	
	To the Hospital or Attens within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and and manner stated. 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and coursed a and manner stated.	d due to the cause at the time, date a	(s) and manner as sind place, and due to	ated. othe cause(s)	
)	To the vithin To the comple	Me	29b. Signature and title of earthier M)) 29c. License number D 3 1 4 6 4	29d. C	Pate signed (Month,	-	
_	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALS A. HASIMM, 821 N. ENTAW ST Soute	308 6			
	Sta Registr		31. Date filed (Month) Day (Year) 2006 32 Registrar's Signature				

			1 - For Stete Registrer	State of N	Marylan		artment of H		and Me		giene leg. No.	2006	20033	
	Physicia	an.	1. Decedent's Name (First, Middle, L	ast)					2	. Date of Dea Month	ith Day	Year	3. Time of Death	
	/Medic		Bernadette Marie Shea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							June 17, 2006 11:10 a * 4c. County of Death				
	Examin	er									1			
H	- Francisco		4988 Ellis Lane 5. Social Security Number 6.	Sex 7.7	Age (In yrs.	last birthday)	Ellicott If Under 1 Year	If Under 2	24 Hrs. 8	. Date of Birtl	2	ward 9. Birth	nplace (State or Foreign	
п	Funeral Director		215-70-0816	1□M 2√2F	41	Yrs.	Months Days	Hours	Min.	(Month, Da) -8-196			vland	
	و ح م		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation						10d. Inside City Limits	
	faryla ehov	٥				•							1 ☐ Yes 2 ☐ No	
	28a-	rect	Maryland Howard 10e. Street and Number		LII.	icott (10f. Zip Code			T	10g. Citi	zen of What Cor		
	within 72 hours after death with the Maryland ene. than "netural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notitied at	Funeral Directo	4988 Ellis Lane				21043				USA			
	eme 2	ner	11. Marital Status	12. Was Deceder Armed Force			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race · American Indian, Black, White, etc.		
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 24 If Yes, Give	□ No	:	1 ☐ Yes 🏌 ☐ No	Specify:				- "	nite	
ë	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates	s:	16a, Dece	dent's Usual Occupa	ation			16b. Kir	nd of Business/l		
7	nin 72 n "na nie die	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4c)r 54)	(Give	kind of work done of DO NOT use retired	durina most	t of working					
212	d with giene er the	E O	12	College (1-40	<i>n</i> 5+)	Homema	aker				Own	Home		
nd	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, La							First, Middle,				
yla	Meni Meni	10	Edgar Paul Spies Elaine M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num								Gove		F- 0-7-1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show any injury or other treumatic event, it a Mindical Examinat must be notified at another.		Patrick Shea- hus				Ellis Lan						ip Code)	
Baltimore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta	, ,	emetery, crei	sition (Name of matory or other plac		Dat			cation - City or 1		
<u>=</u>	it. Pag ntment ntent: njury c		4 Donation 5 Other (Special Service Lice)	cify)	Mean	1	Memorial F	-		006 E	lkri	.dge, MD)	
Ba	Depa Impo any i		May May May	M01234		Ga	ary L. Ka 250 Washi	ufman	Fune	ral Ho ., Elk	me a	t MMP,I ge, MD 2	NC. 21075	
			Onset and De										Interval Between	
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		east	CHOC	es						
П	Examiner			Due to (or	as a consec	juence of):								
		ner	Sequentially list conditions, any county to immodule cause. Enter Underlying	b. Due to [or	as a conseq	uence of):								
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.	***	wanna af):								
760,	ate be executed hysicien and the burial-transit	cal E	,	Due 10 (0)	as a conseq	juence or).								
687	flicate p phys			d										
Вох	h certi	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			3 □Ectopic pregnancy					23d. Date of delivery		
O.	The law requires thet the death certifica sie hes been signed by the attending ph bege 2 should be delached for use as it	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant 9☐Unknowr	t at time of c		Other (specify)					Month	Day Year	
<u>α</u>	thet the ed by detac	/ Ph	Part II. Other significant conditions	s contributing to deat	h but not res	sulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?	
Vital Records,	puires n sign ald be	d by								1 🗆 Y	es 25	⊒Mô 3□Pro	obably 4 Unknown	
000	s been si	Completed								24a. Was		24b. Were au	topsy findings available	
æ	The lav	mo:								autop perfor	med?	death?	completion of cause of	
ita		Bec	25. Was case referred to medical examiner?						of Death	Check only o				
Ž	Physician: this certific al director,	70	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatier		4 🗆 140				Other (Spec	city)	
ů.	De file	i.i	27. Manner of Death 1 Natural 5 Pending		njury Day Year)	28b. Time o Injury	Worl			d. Describe h	iow injury	y occurred		
Division of	Attending r death. ector: After by the fune	Icat	2 Accident investigat 3 Suicide 6 Could no	be See Bless of	Injury - At h	ome farm st	M 1 1	Yes 2 1		f Location (S	treet and	d Number or Ru	ral Route Number,	
<u>≤</u> .	al or A s after at Direct	Certification:	4 Homicide determine	building,	etc. (Speci	(y)	oot, lastory, omoo			City or Tow				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical (29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To the be seminer: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, an th occurred	d due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the Comp	ž	29b. Signature and title of certifier	^			29c. License					e signed (Month		
•	n		M INCH	1) mp				0851	4		(0/20/2	.006	
	10		30. Name and address of person with	Kiseb	ery	3	Print) St	Pnol	PI	Bat	1 imo	ne 21	202	
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32. P 9	istrar's Signi	ature 6	books !							
			JUNAU											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** So SIK 10:50 PM JUNE 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year
Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Months MOM 20F Hours Director April 30,1942 217-19-4475 Korea 64 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-1 ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23s 21043 4916 Ellis Lane Korea death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie markad other than "natural", or item any injury or other traumatic. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Store Owner Grocery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Keuk Nim Kanq ဂ Hae Yoon Suh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3350 St. John's Lane, Ellicott City, MD 21042 Michael Sheo- son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 6/27/2006 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) ²². Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final failure multi organ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):

Hepatocellular Carcinonum

Due to (or as a consequence of):

Hepatitis infection, chronic, viral Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Box 68760. the attending physician be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐No P.O. detached 9☐ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ þe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospitel or Attending hin 24 hours after death. 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D0058779 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10840 Little Patuxent Parkway, Ste 300, Columbia, MD 21044 Karl Kasamon, M.D. 31. Date filed (Month, Day, Year) 2006^{32. Registrar's Signature} State Registrar

		_	For Stata Registrar	State of Maryland / D	Department of H Certificate of L	Death	Rag. N	711116	20035	
	Physici /Medic		 Decedent's Name (First, Middle, Last) Helen Ruth Shaffer 				ate of Death onth D	ay Year	3. Time of Death	
	Examin Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	tal Rose	If Under 24 Hrs. 8. Da (No. Jul)	ate of Birth fonth, Day, Year ne 4, 192	c County of Death O + N 9. Birthpla County Maryl		
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town					d. Inside City Limits	
	deeth with the Maryland ms 23a or 28a-f ehow rranet be notified at	Directo	Maryland Baltimore 10e. Street and Number	2	Essex 10f. Zip Code		10g. C	Citizen of What Country	1 ☐ Yes 21∑ No y?	
	s 23a o	eral D	7 James St.	2. Was Decedent Ever in U.S.	2122		ac or No.	USA 14. Race - American	a Indian	
036	or its	by Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuba	ispanic Origin? (Specify Y In, Mexican, Puerto Rican Specify:	, etc.)	Black, White, etc. Specify: White		
Shoffelf Helenatimore, Maryland 21215-0036	d within 72 hours piene. r then "neturel", ir e Madical Ext	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired School Teac	during most of working f)		6b. Kind of Business/Industry altimore Co. Schools		
and ?	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then 'n any injury or other traumatic event, ITEMS DDGs.	To Be C	17. Father's Name (First, Middle, Last) Earl Sanders	en Sumame)						
Many	alth and N		19a. Informant's Name/Relationship (Typ John Kenneth Shaffe		Mailing Address (Street a James St. Ba				ode)	
More	Pages 1 e		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of ry, crematory or other place Hill Mem. Gat			Location - City or Town		
Balti	permit. Departn Importe eny inju		21. Signature of Fluneral Service License	irkausko.	Bruzdzinsk 1407 Old E	ss of Facility Ki Funeral Ho Castern Aveni	ome P.A. ue Essex	x, Marylan	d 21221	
	Physician		23a. Pagl 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	rations that caused the death. Do	not enter the mode of dyin	g, such as cardiac or resp	iratory arrest.	li li	Approximate nterval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence		Anemia				
3760,	ate be executed hysicien end the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of).					
P.O. Box 68	The law requires that the death certificat ele hes been signed by the ettending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of delivery Month D	/ Pay Year	
	quires that n signed b uld be deta	þ	Part II. Other significant conditions conf	tributing to death but not resulting i	n the underlying cause give	en in Part I. 2	3e. Did tobacco	ouse contribute to the	cause of death?	
Reco	The law requirestell to the second se	Completed					4a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of	
Vital	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital:	oth Oth	26. Place of Death (Che	ick only one)			
Division of Vital Records,	ding Ph h. After th funeral	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	Time of 28c. Injury	4 Nursing Home :	5 Residence Describe how in			
Divisi	al or Attendii efter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, la building, etc. (Specify)	28e. Place of Injury - At home, larm, street, laclory, office 28f. Location (Stree					
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	Medical C		icien: To the best of my knowledge er: On the basis of examination ar and manner stated.						
	Vithin To th	W	29b. Signature and title of certifier		29c. Licens	e number 8 4 8 7	29d. D	Date signed (Month, Da	ıy, Year)	
	5		30. Name and address of person who cor	om Flanklin &	square Dsi	ve Balti	note M	D 2122	7	
.3.	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	J. Sparker		7.1.		1	

State of Maryland / Department of Health and Mental Hygiene 2 🕕 🖰 1 - For Stata Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Stephens 23 5:00 AM Hortense JUNE 2606 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days | Hours | Min. | (Month, Day, Year) Baltimore Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 64 218-19-0802 Yrs. Director Jamaica Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Baltimore M9 Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code AUR 21215 Jamaica 5304 Lanview Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Iteme 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "na eny injury or other freumatic event. The Madia Elementary/Secondary (0-12) College (1-4or 5+) Home Diztary Aide Nursing 6 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Walker Haatha WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) They Step? 20a. Method of Disposition Husband Baltimore Md AUR Stephens 21215 Date 20c. Location - City or Town, State Na Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) woodlawn Cemetery 7/1/06 WoodlawN Md 22. Name and Address of Facility Chatman - Harris Funeral How 21. Signatur Funeral Service Licensee 5240 Reisterstown Bd Baltimore Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ate has been signed by the attending physicien page 2 should be detached for use es the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 No is effer deam. rei Director: After this cer.... 1 Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 📉 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Nafural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei within 24 hours e Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
JUN 2 6 2006 32 Registrar's Signature State Goods) Registrar

DHMH 17 Rev 1/2001

2006

Baltimore,

Box 68760,

P.O.

STEPHENS

HORTENSE

			1- State of Maryland Registrar	/ Department of Health and M Certificate of Death	lental Hygiene Reg. No.	2006 20037
	Dhusis	0.10	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physici /Medio		MARVIN W. TA	10MAS	06 21	2006 42 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. C	County of Death
			505 I street	Oakland		Garrett
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia.		8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		578-52-8564 10M 20F 65	Yrs. World's Days Trouts Will.	October 28, 191	10 Onio
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Tana at a said		10111110
	aryla shov	_		Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8e-1	cto	Maryland Garrett	Oakland		
	iff if	<u>Si</u>	10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show dreal Examiner must be motified at	Funeral Director	505 I Street	21550		USA
	r de	Tue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto) 	ecify Yes or No-	Race - American Indian, Black, White, etc.
36	or It	Y.F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify:
21215-0036	ural	d by	3 Widowed 4 Divorced Year or Dates:			vvnite
Ϋ́	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired)	ing 16b. Kin	d of Business/Industry
2	within ene. then "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	Coal Miner		th Brancha Dobbin
2	a filed of Hygie other t		i C 17. Father's Name (First, Middle, Last)		(First, Middle, Maiden S	
Ĕ	ould be f Mental H karked ot katic evel	Be			lian Dug	
₹	should nd Mer mark	2	George W. Thomas			
Maryland	0, 00 00		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	4	
	1 and 2 Health em 27		Donna Thomas / Wife			21550
altimore,	Pages 1 nent of H nt: If Ite iry or ot		Cer	metery, crematory or other place)		ation - City or Town, State
<u>Ξ</u> .	Pagent:		`4₽Donation 5 □ Other (Specify) Ana:	lomy Gifts Recristry June	21,2006 Har	lover, M.D
ä	permit. Page Department o Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Pacility And	atomy Gifts	Registry
<u> </u>	#Q = 9 g			7522 Connelley Drive.	Svite P. Han	over, MD 21076
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Revol Fo	luve		Onset and Death
	/Medical		resulting in death) Due to (or as a conseque			years
	Examiner		Sequentially list conditions.			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):		
	cutec nd ransi	Examin	that initiated events C.			
Ó	an ar rial-t		resulting in death) Last Due to (or as a conseque	nce of):		
68760	ficate be executed physician and is the burial-transit	edical	d			
_		ledi				
Вох	h cer endir use	N/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal of		23	d. Date of delivery
<u>m</u>	deat e attr	icia	1 Ves 2 No 4 Pregnant at time of dea			Month Day Year
P.O.	that the death certif ed by the attending detached for use a	Physician/M	9 Unknown			
	law requires that the death cert as been signed by the attending 2 should be detached for use a	by P	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
ñ	quire on sig uld b		Gordnary avtery	d1520,50	1 ☐ Yes 2 €	No 3 ☐ Probably 4 ☐ Unknown
8	w rec	Completed	15 Chomic Card	roputhy.	24a. Was an	24b. Were autopsy findings available
æ	9 4 9	Щ			autopsy performed?	prior to completion of cause of death?
a	iclen: Th certificate rector, pag	e Cc	25. Was case referred to medical	ac Class of Death	1 Yes 2 No	1 ☐ Yes 2 ☐ No
Division of Vital Records,	Physiclen: r this certific ral director,	100	examiner? 1 Yes 2 40 Hospital: 1 Inpatient 2 E	26. Place of Death		ETO:
of	Phys r this ral di	: To			me 5 Residence 6 28d. Describe how injury	
on	Attending or death. ector: Afte by the fune	tlor	1 Natural 5 Pending (Month, Day Year)	28b. Time of 28c. Injury at 28c. In		
S	ttendi death. ctor: A y the fu	lica	3 Suicide 6 Could not be 300 Sleep of Laiver, At home		28f. Location (Street and	Number or Rural Route Number.
\leq	after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State)	,
_	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier Certifying Physician: To the best of my knowl	edge, death occurred at the time, date and place of	and due to the cause(s) o	nd manner as stated
	24 h Fun etely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	in and/or investigation, in my opinion, death occurre	ed at the time, date and p	place, and due to the cause(s)
	o the ithin o the omple	Me	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
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	0		J'un Samuel Mil	en like 13 1	6	12/06
	10		30 Name and address of person who completed cause of death (Item 2	(Type, Print)	. Oali.	am Lui
	01		31. Date filed (Month, Day, Year) 32. Degistrar's Signatu	10 0 0 1 TONES &	v Cacc	1111
	Sta Registi		HIN O. C. 2006	! boarde		13150

Please Type or Print in Black Indelible Ink

/ashington R. V	1	State of Maryland / Department of Health and Mental Hyg For State Certificate of Death	giene Reg.	No. 20	06 2003
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Last) R. Virail	Date of Death Month D June 22, 20	Day Year 06	3. Time of Death 0312 hrs
	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Mercy Hospital Baltimore		4c. County of De	A
Funeral Director	{	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth	For	Birthplace (State or eign Country) Georgia
th the Maryland 33a or 28a-f show any polified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Alabama NA OZARK 10e. Street and Number 10f. Zip Code 302 Willow Ridge Lane 36360		. Citizen of What Co	A
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	by Fune	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of wording most of working life DO NOT use retire	ork done	14 Race - Am White, etc Specify: 6 6b. Kind of Busines	Black
8 = . ≣ ≝	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Pastor 17. Father's Name (First, Middle, Last)	First, Middle, Ma	Baptis Biden Surrame)	st Church
2121; hould be fill and Mental be is marked attic event, t	8	Washington Virgil Lula 19a. Informant's Name/Relationship (Type, Print) (Brotker) 19b. Mailing Address (Street and Number or Ru Rev Frances & C. Vive Co. D. C. Boy S. 14	Bell ural Route Number	er, City or Town, Sta	aders ate, Zip Code) 31799
Baltimore, MC permit Pages I and 2 si Department of Health an Important: If item 27 injury or other traums		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: West Side Cemetery 7///	Date 2006	20c. Location - City	or Town, State
Baltimo permit Page Department of Important:		222 W.North Ave.	negal H Balt respiratory arres	0, Ma, 2	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
xecuted n and I - transit	cal Exa	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	icy	23d. Date of deliv Month	ery Day Year
, P.O. B res that the d signed by the be detached	Ş	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus	23e Did toba		to the cause of death?
Records, The law requir	Completed		24a. Was an autopsy perform	prior to death	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	To Be	27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)	Home 5 R	esidence 6 Ot	her:
Divisior pital or Attend ours after death leral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str or Town, Sta		Rural Route Number, City
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	the time, date ar	nd place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (i	•
5		 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 31. Date filed (Month, Day, Year) 32. Registrar's Signature 	201		
St Regis	ate trar	111N 0 6 2006 Steam of Signature			

State of Maryland / Department of Health and Mental Hygiene 20039 1 - For Stata Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Virginia 06-18-2006 Waugh 2:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Forest Hill Health & Rehab Center Forest Hill, MD Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 10, 1930 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 TyF Days Hours 217 24 9318 76 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir then "netural", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt "2D" 21220 206 Midlass Drive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after d al Hygiene. other them "netural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygien Important: If Item 27 is marked other I eny injury or other treumatic event. Lagge. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Herman Eiler Anna Jondo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxannne Beavers daughter 109 Fitzhugh Road Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 6/20/2000 Baltimore County Md Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Fineral Sirvice Linensee 1407 Old Eastern Avenue Essex Maryland 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Pa 11. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Imm wir te Cause (Final disease or condition chronic obstructor pulmonny Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate **2**□ No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after e Funerel Direc 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032279 JUNE 17, 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Dunn, 615 West Macphail Rd, Suite 106, Bel Air, MD 21014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State doarle JUN 2 6 2006 Registrar

		T = For State Registrar	State of	Maryland / E		cate of L		IIIO IVIC		Reg. No.	006	20040	
Dhami		1. Decedent's Name (First, Middle,							2. Date of De Month	ath Day	Year	3. Time of Death	
Physic /Med		George G. Wa							June	23	2006	6:45a M	
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70		Usual Residence of Decedent							PALCII	20713	<u> </u>	y Luisa	
nyian how		10a. State 10b. County		10c. City, Town		i						10d. Inside City Limits	
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d be f	Be	George Gilbert W				1			Kiebler		mame,		
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lith and Mental Hylgiene. 27 is marked other than "natural", or reaumatic event, the Medical Exami	10	19a. Informant's Name/Relationship		19b.	. Mailing Add						own, State, Zij	Code)	
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S 1 a of Hein other		20a. Method of Disposition		20b. Place of	Disposition	(Name of or other place	9)	Da	ite	20c. Loca	tion - City or T	own, State	
Page Page nent c		XX Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe						une 2	26,200	Balt	imore,	Maryland	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any figury or other traumatic event, the Madical Examiliar mast be notified at		21. Signature of Filheral Paprice Li	CHUSEE	5		e and Addres			Homo	D 7			
m goes	1	1	_	>	140	7 012 1	Faste	nerar	. HOME	Fogov	י האו	21221	
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	Physici		Miu-Yin Yiu	,				June	20 20	2006	7:10P M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deatl	1	4c. Count		7.101
	Examili	ier	8334 Sand Che				ırel		НС	ward	
	Funeral		Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			ce (State or Foreign
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	Pe M	Director	MD Howard		Laurel	1.01.71.0			40-022		
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21215-0036	72 hours after death with the Maryland Instural; or Items 23s or 28s-f ehow dical Essoliner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specia	y Chine	ese
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Maryland		ဥ						Hinh L			
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	s 1 and 2 f Health i item 27 i		Vivian Yiu (I	aughter)	229 20b. Place of Dispo		e Lane F	OCKVL I I	20c. Location		n Ctata
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Baltimore,	permit. Pag Department Importent: I any injury o		4 Donation 5 Other (Specify		Metro Cr			6–2006	Catons	ville,	MD
Ba	Depa impo any i		21. Signature of Funeral Service Licen	Zu Viana.	W	Name and Addr Litzke Fu	meral Ho	nes, Inc			
	_		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	dications that caused th	e death. Do not ent	555 Twin	Knolls ing. such as cardiac	Rd. Col	umbia,) 45 Approximate
			shock, or heart fatture. List only of Immediate Cause (Final	one cause on each line.	to at	11.	/			l l	nterval Between Onset and Death
E	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	10510	MC	Lung	Ca	ncer	7	-years
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Box	death certitica e attending ph id tor use as th	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [Ectopic pregnanc	су			ate of delivery	
	nt the dea by the al tached to	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death 5	Other (specify) _			IVI	511(11	ay Year
P.0	that the ed by detacl		Part II. Other significant conditions or	ontributing to death but r	not reculting in the u	adorhina couso a	won in Part I	23a Did I	tobacco uso con	tributa ta tha	cause of death?
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Division	i or Attending atter death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury	- At home, farm, str			28f. Location (Street and Num	ber or Rural F	Route Number,
Ö	al or / s atter if Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in D		231 Certifier 18 Certifying Phy	micran: To the best of a	ny kinowludgo, death	conumed at the t	kno, data and place	and due to the	cause(s) and m	amer as stat	6d.
	he Hu in 24 he Fu pletel	Medical	(Check only 2 Medical Examone)	iner: On the basis of ex and manner stated	d.	vestigation, in my	opinion, death occu	rred at the time,	date and place,	and due to th	ne cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	10	1	1	se number		29d. Date signe		•
	_		Edward	& The	AM	775	23601		June	51,2	.006
	11		30. Name and address of person who d	cause of deat	th (Item 23a) (Type,	Print)				35	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Edward J. Lee, M.D. 11065 Little Patuxent Pkwy Columbia, MD 21044

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:178M **Physician** 21 MAXINE ANDES JUNE 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE. MULTICARE CTR 700 W 40 x BACTIMERE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 4, 1921 5. Social Security Number **Funeral** Days 1□M 2\ F Yrs. Pennsylvania 219-14-1737 Director Usual Residence of Decedent 10d. Inside City Limits the Merylend 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryle Department of Health end Mental Hyglene. Important: If item 27 is merked other than "natural", or items 23a or 288-f show any highry or other traumetic event, the Medical Examiner must be notified at once. 1 No 2 No **Funeral Directo** Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 4417 Falls Bridge Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Apartment Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Andes Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn O'Brien/Friend 1434 Redfern Avenue Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 6/22/06 Ballinger, 100.

22. Name and Address of Facility Cremation Society of MD, Inc.

MD 21228 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Agensee 299 Frederick Road Baltimore, MD 21228 Edward A regorchik 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this cardificate has been considered to the Funeral Director: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 DiNatural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signature á 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Clearles ST Phonore WD 2/204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 20043 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician CHLOE **ELIZABETH** June 2006 ANDRIST 1:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8255 Severn Orchard Circle Severn Anne Arundel 8. Date of Birth (Month, Day, Y Mar. 17, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 2005 Months Days Hours 1 ☐ M 2 ☐ F Yrs Maryland 219-71-5257 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8255 Severn Orchard Circle 21144 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, iled within 72 hours after de Hygiene.
Hygiene. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify. Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-N/A N/A is 1 and 2 should be filed w Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cara Elizabeth Beck Joseph Richard Andrist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i Cara E. Andrist 8255 Severn Orchard Court Severn, MD mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 (ment of I) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dale Cemetery 7/3/2006 Beaverton, Michigan 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. ≠ M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Progressive Primitive Neuro-Ectodermal Physician /Medical Due to (or as a consequence of): Tumor of the Brain Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 3 Probably 4 Unknown 1 ☐ Yes 2 💢 📉 o pieted 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2℃XNo certificate has Com To the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 XXesidence 6 Other (Specify) 1 ☐ Yes 2/CXNo 1 Innatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Watural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055584 June 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian R. Rood, M.D. 111 Michigan Ave., NW Washington, DC 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8,19b,perFH,0857,7/10/06 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - For State Registrar	State of Ma	rytand / De	ertificate	of Death	o Mental H	Reg. No		20044				
	Dhunisi		Decedent's Name (First, Middle, Las.	1)				2. Date of D Month	eath Day	y Year	3. Time of Death				
	Physici /Medio		Christine Lore	tta Ander	son			June	24		4:06 P M				
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Location of D	eath	4c.	County of Death					
8	sky Zemen		5614 Patterson				iverdale			rince Ge					
	Funeral Director		408-68-7780	7. Age	(In yrs. last birthd	Months		Hrs. 8. Date of B Min. (Month) Dec. 1	irth Day, Year) 5 19	9. Birthp Coun 43 Tenr	lace (State or Foreign try) 165566				
1111	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				11	Od. Inside City Limits				
	e Ma	Director	MD Prince G	eorge's	Riverd	ale					1 Yes 2 No				
	ith th or 28	Jire	10e. Street and Number			10f. Zip (Code		10g. Cit	izen of What Coun	try?				
	23a	rai	5614 Patterson R	oad			20737			USA	4				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mudical Exatra are must be invidiged at Ande.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3√√Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XXN If Yes, Give Year or Dates:	Ever in U.S.		nt of Hispanic Origin' y Cuban, Mexican, P XNo <i>Specify:</i>	? (Specify Yes or N uerto Rican, etc.)	lo-	14. Race - Americ Black, White, of Specify: Whi	etc.				
20	72 hc	etec	15. Decedent's Ed (Specify only highest grad	ucation	16a. De	cedent's Usual	Occupation done during most of	working	16b. K	ind of Business/Inc	dustry				
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+) /if	e. DO NOT use	retired)	wo.ming							
2	lled w tygie her t	ပိ	12th 17. Father's Name (First, Middle, Last)	Ø	Hom	emaker	10 3404500	Name (First, Middl		Own Hom	ne				
Maryland	ntal had of	Be	Harry Fair					ances Ash		Sumame)					
Ë	hould d Me mark matic	ပု	19a. Informant's Name/Relationship (T	ivna Print)	19h M	ailing Address /	Street and Number of	r Bural Bouta Num	her City o	r Tours State Zin	Codal				
<u>8</u>	id 2 s ith ar 27 is trau		Rebekah Shawn You		700	A Pock	Elm Court	Odenton	MD.	21113	0000)				
ē,	Hea Hea tam		20a. Method of Disposition	ng/ Daugnet	20b. Place of Di	sposition (Name	e of	Date	-	cation - City or To	wn, State				
9	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3\(\) 4 ☐ Donation 5 ☐ Other (Specify)			crematory`or oth 'allev C	emetery 6/	/29/2006	Elia	zabethtor	ı. TN				
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service licens	600		22. Name and	Address of Facility	Donalds	on Fu	neral Ho					
	0 D ≥ € 0	2 1	James Van		100160		lbott Aven			D 20707					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do not e.	enter the mode	of dying, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death				
	Physician		disease or condition resulting in death) Cardiac Arrest												
şi .	/Medical Examiner		resulting in dealiny	Due to (or as a	a consequence of):										
		-E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):										
	nsit M ted	Examiner	Cause (Disease or injury												
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a	consequence of):										
68760,	tificate be executed go physician and as the burial-transit			d.											
68	lificat g phy as th	ledicai													
.O. Box	res that the death cer igned by the attendin be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spec				23d. Date of delive Month	ry Day Year				
<u>α</u>	The law requires that the ate has been signed by the bage 2 should be detache	by Pt	Part II. Other significant conditions co	ntnbuting to death bu	it not resulting in th	e underlying cau	use given in Part I.	23e. Did	tobacco u	se contribute to th	e cause of death?				
Vital Records,	quire an sig uíd b	d ba	Hypertension					_ 1 🗆	Yes 2	□No 3□Proba	ably 🗱 Unknown				
000	aw requir s been si 2 should i	Completed						24a. Wa		24b. Were autop	osy findings avaitable				
æ	The lav	E						perf	opsy formed?	prior to con death? 1 🗌 Yes	npletion of cause of				
ital		a	25. Was case referred to medical				26. Place of	Death (Check only	one)	1 103	∑r ¥140				
\$	S S ID	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospitat: 1 ☐ Inpatier	nt 2 ER/Outpa	tient 3 DOA	Other: 4 Nursin	ng Home XX Res	sidence (6 ☐Other (Specify)				
Division of	ding Phy. h. After thi funeral		27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur	У	c. Injury at Work?	28d. Describe	how intur	y occurred					
<u>is</u>	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	ry - At home, farm,	M Street factors	1 Yes 2 No	28f Location	(Stroot an	d Number or Rural	Gouta Number				
Ω	tal or A s after al Dire	Certification:	4 Homicide determined	building, etc	. (Specify)	Street, raciory,	onice		wn, State		noute Number,				
	To the Hospital or Attsm within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner state	examination and/o	eath occurred at r investigation, ii	the time, date and pl n my opinion, death o	lace, and due to the occurred at the time	cause(s) , date and	and manner as sta place, and due to	ated. the cause(s)				
	To the within 2 To the complet	Med	29b. Signature and title of certifier			29c.	License number		29d. Dat	e signed (Month, L	Day, Year)				
	⊢s⊢ŏ		· lu		111		D00583	290		6/26	106				
	3		30. Name and address of person who c	ompteted cause of de	path (Item 23a) (Tvi		- 0300				1 -10				
	1 "		4203 Queensbury				781 Dr	. Mattath							
24	Sta		31. Date filed Month, gay: 1462006	Jan Haystra											
18	Registr	ar													

06-04298 Tulio Fenez Aguilar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 20045

		1- For State Registrar		Cert	ificate of	Death			Reg No	6-m	000	2009
Physicia		1. Decedent's Name (First, Middl		2. Date of	Death			Time of Death				
ledical Exami	ner	TULIO FUNES AC	GUILAR					June 1	19, 2006	Yea		2300 hrs
		4a. Facility Name (if not institutio Nerthwest Hospital	n, give street and num	ber)	4	b. City, Town, or		Death		c. County o	f Death e County	
						Randallstow						
Funeral		Social Security Number	6. Sex 7	. Age (in yrs. las	t birthday)	If Under 1 Year Months Days	+	Min. 8. Date	of Birth(MM	/DD/YYYY)	9 Birthpla Foreign	ace (State or
Director		215-51-8020	1 XM 2 F	20	Yrs.	Working	710010	07	/21/1	985	Country	y) HUNDURAS
		Usual Residence of Decedent										
v any		10a. State 10b. County		10c. City, T	own or Location	on						d. Inside City Limits
and shov	اۃ	MD BALTI	EMORE	OWI	NGS MI	LLS					1	Yes 2 No
Maryland 28a-f show 1 at once.	ect	10e. Street and Number				10f. Zip Code			10g Cit	izen of Wh	at Country?	,
ith the Maryland 23a or 28a-f sho notified at once	Director	57 TOHAE CIR.	_ APT C			21117			н	JNDURA	24	
with IS 23	<u>a</u>	11. Marital Status	12. Was Dece	dent Ever in U.S		Decedent of His		n? (Specify Yes	or No-			Indian, Black,
leath r iten	Funeral	1 Never Married 2 Ma	arried Armed For	ces? 2 🗶 No	If Ye	es, specify Cuban	, Mexican, I	Puerto Rican, etc.	.)	White	, etc.	
fter o	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	- 23 110	1 🗶	Yes 2 No	specify:	HUNDURAS		Specify:	WHITE	
ours a		15. Decedent's Education (Spec		completed)		's Usual Occupati			16b.	Kind of Bus	siness/Indus	stry
72 h	ompleted	Elementary/Secondary (0-12)	College (1-4	1 or 5+)	auring ma	st of working life.	DO NOT U	ise retirea)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	E I	7TH			COOK					RESTA	AURAN'I	ני
5-0 Hygi	O	17. Father's Name (First, Middle,	Last)			1	18 Mother's	Name (First, Mid	dle, Maider	Surname)		
be fi	8	MARCO T. FUNES						IA E. FUR				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sh matic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relations						per or Rural Route				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		REYNA E. FUNES	S/MOTHER	Loo. o	57 TO	HAE CIR.	– AI	PT. C. OV	VINGS	MILLS	S, MD	21117
Baltimore, permit. Pages I ar Department of Her Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from	1	ace of Dispositematory or other	tion (Name of cen er place)	· ·	Date			City or Tow	* -
Page nent or otl		4 Donation 5 Other Sp	pecify:	luy				7-1-0	6 1	lun	du	cas
alt.		21 Signature of Funeral Service	Licensee		22. Na	ame and Address	of Facility	WESLEY (CHAVIS	JR.	FNRI	. HM.
2.2 2.5 00		Wesley C	herry	-	2	007-09 E	ASTER	N AVE	BALTI	MORE.	MD	21231
Physician /Medical		23a. Part I. Enter the disease, or failure. List inly one cause		used the death. I	o not enter th	e mode of dying,	such as ca	rdiac or respirator	y arrest, sh	ock, or hea		pproximate Interval Between Onset and
Examiner		Immediate Cause Inal disease										Death
£ "		or condition resulting in death)	Due to (or as a c	consequence of):								
•	<u>,</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a c	onsequence of):							_	
	Ě	cause. Enter Underlying Cause										
d d	Examin	events resulting in death) Last	Due to (or as a c	consequence of):								
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D, be ex sician	n/Medic	UNPENDED	AMENDED									
8760, tificate bong physic as the bur	Š	IF FEMALE: 23b. Was decedent pregnant in th		utcome of pregna	•	al death 3	Catania	pregnancy	23	d. Date of	•	V
certi		past 12 months?		nt at time of deal	2 Feta	er (S <i>pecify)</i>	Ectopic	pregnancy		Month	Day	Year
Box 687 The death certific The attending price as the	hysicia	1 Yes 2 No 9 Uni	known 9 Unknov	vn	□ OIII	er (opecity)			Î			
O. I tt the lby tl	٥	Part II. Other significant condit	ions contributing to	death but not res	sulting in the ur	nderlying cause g	iven in Par	t I. 23e. I	Did tobacco	use contrib	oute to the c	cause of death?
res that the signed by	d by							1	Yes 2	/ No 3	Probably	4 Unknown
ds requi	Completed								Was an			y findings available
CO law law e 2 sl	μ								autopsy performed?	de	eath?	letion of cause of
Re Ficate	ပိ	05 10/	. 1			00 DI	- (D		res 2 N	1	✓ Yes	2 No
of Vital Records, g Physician: The law require ufter this certificate has been s meral director, page 2 should t	Be	25. Was case referred to medica examiner?	Haspital:		TD/O: 44:4		Other -	Check only one)			7.00	
fV Phys er this	မ	1 Yes 2 No 27. Manner of Death	28a. Date o		R/Outpatient 28b. Time of In	النشا	y at Work?	Nursing Home 5	ribe how inj	ence 6	Other:	
n of iding Ph	Certification:	1 Natural 5 Pend	(Month of	Day Year)	0000 hrs		'es 2 ✓ I	Passeno	ger of aut	to involve	ed in coll	sion
Sion Attender death ector: by the	cati		stigation	of Injury - At hon	no form stroot	t, factory, office be			on (Street)	and Mumba	r or Durol D	Route Number, City
Division pital or Attendir ours after death. eral Director: A	ij	dete	id not be	Major Road		i, ractory, office of	allaling, etc.	or To	vn, State)			toute Number, City
ospit hour uners ly fill	1	4 Homicide				and set the stime of the			und I-79	•		-
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical		hysician: To the best miner:On the basis of	examination and								use(s)
To To	Med	29b. Signature and title of certifie	and manner sta	ited		29c. License					d (Month, L	
	100		111	1/		O.C.N	M.E.			ie 20, 20		
(30. Name and address of person	JVYI. a	of death (Harris	33)					-,		
H			outy Chief Medica			n Street, Balt	imore. M	1D 21201				
1	tate	· · · · · · · · · · · · · · · · · · ·		strar's Signature								
Regis		JUN 2 7	2006	Aug . A		No 2						
	2004		A STATE OF THE PARTY OF THE PAR	30.00	The same of the sa							

		-	For State Registrar	State of	Marylan	-	artment rtificate			and M	lental Hy	giene /	2006	20046
	Physicia	an	1. Decedent's Name (First, Mid Martin Adam A								2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institute		ther)		4h City 1	own or	Location o	of Death	June		006 ounty of Death	7:05M
	Examin	er	3141 Strickla		10617				more	Dogui		40. 0	N/A	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)				24 Hrs. Min.	8. Date of Birt	th V Year)	9. Birth	place (State or Foreign
	Director		218-90-6813	XXM 2□F	42	Yrs.	Months	Days	Hours	WINT.	8. Date of Bin (Month, Da Oct. 27,	1963		yland
	and	1	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Maryl f eho	ō		/a	ī	Baltim	ore						-	1 X Yes 2 □ No
	r 28a	irec	10e. Street and Number	,		3020211	10f. Zip	Code				10g. Citize	n of What Cou	intry?
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Modicel Exercitive must be notified at	Funeral Director	3141 Strickla	nd Street					21229)		Uni	ted Sta	tes
	or dea	nue	11. Marital Status	12. Was Dece Armed For	ces?	S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	. Race - Amer Black, White	
36	rs afte	by F	1XXNever Married 2 Married 3 Widowed 4 Divorce	If Yes Give	9		1□ Yes 🕏	SNo.	Specify:			s	pecify: Wh	ite
9	2 hou		15. Decede	ent's Education		16a. Dece	dent's Usua	Оссира	ıtion			16b. Kind	of Business/li	ndustry
215	thin 7; B. n. "n	Completed	(Specify only high Elementary/Secondary (0-12	nest grade completed) College (1-	-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired)	uring most	t of worki	ing			
2	ed wit ygien yer the	Con	10		,	True	ck Dri						stal Cr	ane
pur	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle								(First, Middle,		•	
Z Z	hould d Mer marke matic	ဥ	Joshua Albright			19h Maifi	ng Address	/Street 2			e Lucil			in Code)
S S	id 2 s Ith an 27 le r		Bernice Albric		•)		Centi				st. Deni			
ē,	s 1 ar f Hea Item		20a. Method of Disposition		20b. P	lace of Dispo					Date		tion - City or T	·
Ë	Page nent o int: If		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other							ark	6/22/06	Elkı	idae.	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 Ie marked other then "natural", or Items 23a or 28a-f ehow eny Injury or other traumatic event, the Modical Examiner must be indiffied at once.		21. Signature of Funeral Service	e Licensee	/	2:	Name and	Addres	s of Facilit	v				
_	20 E 9 9		Maple	the wa	ns						eral Ho d. Elk		, Mb'2	
			23a. Part1. Enter the disease, shock, of heart faifure. Li	st only one cause on ea	ach line.				j, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical	1	Immediate Cause (Finaf disease or condition resulting in death)	- a.		CAL) (5K	Name .						MONTHS
	Examiner			Due to (d	or as a consequ	uence of):								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a consequ	uence of):								
Ells:	icuted nd transit	Examiner	triat initiated events	C										
760,	ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (d	or as a consequ	uence of):								
687	\$ \$ B	dicai		d										
Вох 6	death certifical e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								23	d. Date of delik	rerv
ĕ	death a atter d for u	iciar	in the past 12 months?	4□Pregna	rth 2 □ Fetat ant at time of de		∃Ectopic pre ∃ Other (s <i>p</i> e						Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown	9□ Unkno	wn									
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Division of Vital Records,	elaw hast ja 2 s	Completed									24a. Was autop		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
<u>a</u>	ilcian: The l certificate ha rector, paga	e Co	25. Was case referred to media								1 Yes	21 No	1 🗆 Yes	2 No
Ξ		To Be	examiner?	Hospital:	npatient 2	ER/Outpatier	nt 3□ DO	Othe			me 5 Resid		Other (Spec	(6z)
٥	g Physier this		27. Manner of Death	28a. Date o	of Injury on, Day Year)	28b. Time o		Bc. Injury Work	at		28d. Describe I			''y)
ior	endin sath. or: Aft	atio	E Accident	stigation	,, July 1041)	injury	М		res 2 🗆 i	No				
ξ	al or Attending P s after death. Il Director: After t id in by the funera	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	minod 289. Place	of Injury - At ho ng, etc. <i>(Specif</i>)	me, farm, st	reet, factory,	office			28f. Location (3 City or Tox		Number or Rui	al Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in	S	29a. Certifier Certifi	ying Physician: To the	back of my back	ladaa daat	h			d alassa				
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	edicai	(Check only 2 Medic	al Examiner: On the ba and mann	isis of examinat	tion and/or in	vestigation,	in my op	e, date and inion, deal	th occurr	ed at the time,	date and p	lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tipe of certi	tier /	12	-2)	29c.		number	67			signed (Month,	
	1		pr/2	Jornely	L W			D	185	8+		101	7 20	2006
	4		30. Name and address of person					A	رص	/-	2014.		Mis	2006
	Sta	te	31! Date filed (Month, Day, Yea	ar) 32. Re	900 egistrar's Signa	ture	4	/ 1 0		14	١١٧٧١١		""	- ' /
	Registi		JUN 27	2006	w Si	ROSA								

			1 - For State Ragistrar	of Marylan		rtment of H		Mental H	ygiene Reg. No	e 0 0 0	20047
4.	學		Decedent's Name (First, Middle, Last)					2. Date of D	eath Da	ıy Year	3. Time of Death
	Physici /Medic		Mary T	hompson	Arthur	•				2006	7:32A M
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of De	ath	40	c. County of Deat	1
		S MA	10233 Gainsborough Roa 5. Social Security Number 6. Sex		141:-1-1	Potomac If Under 1 Year	If Under 24 H	rc 0 D-1(D		Montgome	
746	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F	7. Age (In yrs. 85	Yrs.	Months Days	Hours Mi		ay, Year	9. Birti Co Mars	nplace (State or Foreign untry) 7 Land
70		1	Usual Residence of Decedent	05				Sciencery	0, 1.)21 Hai.	, s.and
	how tow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Ma	cto	Maryland Montgomery		Ро	tomac					1 ☐ Yes 2 💆 No
	or 28	Dire	10e. Street and Number	_		10f. Zip Code				itizen of What Co	*
	a 23a	Frai	10233 Gainsborough Roa		6 12 1	208		(Casal, Vacas)		ted Stat	
36	be filed within 72 hours after deeth with the Maryland at Hygiene. A control of other than "natural", or itema 23a or 28a-f show other than "natural", or itema 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes.	ecedent Ever in U Forces? s 2 \ No Give r Dates:		Vas Decedent of Hi i Yes, specify Cuba □ Yes 2∏ No	n, Mexican, Pui Specify:	erto Rican, etc.)	10-	14. Race - Ame Black, White Specify: Wh	e, etc.
ခို	2 hou	ted	15. Decedent's Education		16a. Deced	ent's Usual Occupa	ation		16b. h	(ind of Business/	ndustry
212	thin 7 9.	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	e (1-4or 5+)	life. (kind of work done of OO NOT use retired	furing most of w ()	vorking			
7	ed wil	Con	2		Ger	ealogist				Genealog	<u>y</u>
Maryland 21215-0036	d ta b	Be	17. Father's Name (First, Middle, Last) Maurice Raymond Thomps	on				_{lame (First, Middi} e Howard		n Sumame)	
Ĕ	id 2 should th and Men 27 is marke traumatic	은	19a. Informant's Name/Relationship (Type, Print)		19h Mailin	g Address (Street a				or Town State 7	in Code)
<u>S</u>	and 2 s ealth an n 27 is nar trau		Bruce Thompson Arthur /	/ Son		tevenson					
ē,	ーゴーサ		20a. Method of Disposition	20b. F	lace of Dispo:	sition (Name of	1	Date		ocation - City or	
E E			1 🔀 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	om State A11	Hallo rch Ceme	natory or other plac WS Episcop	ăl Jui	ne 28, 2006	Dav	idsonvil	le, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	M0130	Ro	Name and Address bert A. Pun	s of Facility	neral Home	/Bethe	esda-Chevy	Chase, Inc.
1 to			23a. Part1. Exter the disease, or complications that	at caused the deat		57 Wisconsi or the mode of dyin				yland 2001	Approximate
	Physician		shock, or heart failure. List only one cause o Immediate Cause (Final disease or condition	etastatio	. Carci	noma Sar	come of	Overv			Onset and Death 18 Months
	/Medical		resulting in death)	to (or as a conseq	**********	.IIOma Jai	COMA OI	Ovaly			10 Honens
- 15 - 15 - 15 - 15	Examiner		Sequentially list conditions b.								
. \$6	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conseq	uence of):						
	and and Il-tran	хап	that initiated events c.	to (or as a conseq.	uence of):						
8760	cate be executed physician and the burial-transit	dical E		, , , , , , , , , , , , , , , , , , , ,							
68/	ficate g phys	edic	d.								
Вох	death certificate be executed e attending physician and id for use as the burial-transi	Physician/Med		outcome of pregna		E-A			1	23d. Date of deli	very
n	death	sicia	in the past 12 months?	e birth 2 🗌 Feta egnant at time of d aknown		Ectopic pregnancy Other (specify)				Month	Day Year
О	at the de I by the stached	Phys	9 Unknown								
Vital Records,	The law requires that the tee has been signed by th page 2 should be detache	by	Part II. Other significant conditions contributing to Congestive Heart Fail		ulting in the ur	derlying cause give	en in Part I.			_	the cause of death?
မင္ပ	law ri as be 2 sh	Completed						24a. Wa	s an	24b. Were au	opsy findings available ompletion of cause of
		Соп						per 1 Tyes	ormed? 2 X No	death?	2 No
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?			To:		eath Check only			
	this al du	. To		☐ Inpatient 2 ☐	ER/Outpatien	3 DOA Othe	or: 4 Nursing	Home 5 N Res			ify)
0	fing After fune	tion	1 Natural 5 Pending (M	ionth, Day Year)	Injury	28c. Injury Work	rat ?? Yes 2 □ No	28d. Describe	now inju	iry occurred	
Division of	al or Attending : after death. I Director: After d in by the fune	ertification:	3 Suicide 6 Could not be	ace of Injury - At ho	ome, farm, stre			28f. Location	(Street ar	nd Number or Ru	ral Route Number,
á	= 9.5	Cert	4 Homicide determined bu	ulding, etc. (Specif	y)			City or To	wn, State	9)	
	To the Hoepital or within 24 hours afte To the Funeral Dir.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and m	the best of my kno e basis of examina anner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my or	e, date and pla- pinion, death oc	ce, and due to the curred at the time	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	ite signed (Month	Day, Year)
	4		Lund M /	nell_		D3!	5996		June	e 23, 20	06
n	o,		30. and address of person who completed ca			•					
	,		Linda M. Burrell, M.D.			ty Blvd.	West,	#400, Si	1ver	Spring,	MD 20902
	Sta Registr			. Registrar's Signa		beste					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 20048 State Registrar Amend Item #10c Per FH 8856 6/2 1966 SH Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 23, 2006 8:25pm Auneita F. Ashe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4607 Powell Avenue Overlea Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K 215-28-2493 74 Maryland Director March 2, 1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State marked other then "natural", or items 23a or 289-1 ehow imetic event, the Mydical Examinar mast be notified at 1 ☐ Yes 2 No Directo Overlea MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4607 Powell Avenue 21206 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Supervisor Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Melvin Chilcoat Bertha Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page.
Department of Hean.
Toortent: If Item 27 Melanie Utterback, daughter 2516 Glencoe Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriel 2 ☐ Cremation 3 ☐ Removat from State Important: If eny injury or once. Gardens of Faith June 28, 2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalaye of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 6415 Belair Road, Baltimore, Maryland ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death 23a. Part 1. Epter the disease shock, or heart faifure. L fmmediate Cause (Final disease or condition resulting in death) **Physician** vorary artery decea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed by the attending physicien and tached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown been signed by should be detach Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? this certificete 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? After 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident in by the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

within 24 hours a

To the Hospitel

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

cai

31. Date filed (Month, Day, Year) 7 2006

MIKEWALOUSU



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

121002

29d. Date signed (Month, Day, Year)

			i icuse	State of Maryland				Mental Hygid	_	
		•	1 - For State Registrer	orace or maryland		rtificate of L			2006	20049
			Decedent's Name (First, Middle, Last))				2. Date of Death		3. Time of Death
	Physici	-	Lillian P	Slanchard				Month /	Day Year	12:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	1	4c. County of Deat	h
		· Marie		te			DAC		AIN	
	Funeral		5. Social Security Number 6. Se	TM 0/90 F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,)		hplace (State or Foreign untry)
	Director		219-40-3272 Usual Residence of Decedent	42	115.			5/24/	1944	MD
	rland ow	}	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man a-f eh	ţō	A/N AM	Pal	time	Re				1 ⚠Yes 2 □ No
	or 28	Director	10e. Street and Number	_		10f. Zip Code		100	g. Citizen of What Co	untry?
	death with the Maryland rns 23a or 28a-f ehow	rail	718 Allendale	Street		2133	9		15A	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. \	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
5	hours after ture!; or its al Examine	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∏ Yes 2 📉 No If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	00 X
12-0036	2 hou		15. Decedent's Edu	cation		dent's Usual Occupa		16	6b. Kind of Business/	Industry
2	within 72 ane. then "ne'	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of DO NOT use retired	turing most of woi)	rking	_	
7	ygien yerth t, the	Completed	12th Grade	NA	ASS	embler		7	baxter C	empirels
and	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then "neture!; or items 23s or 28s-1 shows event, the Medical Examirer must be rediffied at	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma	,	
~	should nd Mer marke	ဥ	19a. Informant's Name/Relationship (7)	CKS	10h Mailir	og Address (Street s	Laura	L. UZZ	City or Town, State, Z	in Code)
Z Z	nd 2 sl alth an 27 io r r traur		Robert A. Rick			Leewoo	. \	talt more)) C
စ်	s 1 and if Health item 27 other ti		20a. Method of Disposition	20b. Pf	ace of Dispo	sition (Name of			Oc. Location - City or	Town, State
Ê			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	$pod \alpha$	natory or other place	. /	14/06 P	an Ila	a Mi
gaitimore,	permit. Page Department of importent: if eny injury or once.		21. Signature of Funeral Service Licens	88		2. Name and Addres		Funeral &	Syc.	26 14617
מ	80 E 8		Vaugho C	, Greene		51 Patto.	Nati Fix	se Baltin	rope, MD	21239
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the death ne cause on each line.	. Do not ent					Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	ENOX	tage	Chron.	L Ohoon	she RI I	SIGNAL	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					0
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	uted J nnsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,					
-	be executed sicien and burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	ence of):					
200	± ≥ 5	icai	(d						
200	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:							
X Q Q	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
	the de ry the e	ysic	1 ☐ Yes 2 ๋ C No 9 ☐ Unknown	4∏Pregnant at time of de 9□Unknown	ath 5L	Other (specify)				,
7.	uires that th signed by t Id be detach		Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ras,	The law requires that ite has been signed b age 2 should be deta	ed by	Lung Concer	PA				1 🗆 Yes	2 □ No 3 @ Pro	obably 4 Unknown
Hecord	aw requir s been si 2 should l	piete	Dipholes mellins	, Chrmic le	c. In.	4 Diges	-je	24a. Was an	24b. Were au	topsy findings available
	The late ha	Completed)		9		autopsy performe	ed? death?	ompletion of cause of
Vital	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?					ath (Check only one)		
0	Attending Physician: r death. sctor: After this certific by the funeral director,	2	1 Yes 2 No		ER/Outpatien		4 Nursing F		ce 6 ☐Other (Spec	city)
	Jing F	Hon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat t? Yes 2 ∐No	28d. Describe how	injury occurred	
UNISION	i or Attendii efter death. Director: Al in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str		2 2 110	28f. Location (Stre	et and Number or Ru	ral Route Number.
	- 8 -	Certification:	4 Homicide determined	building, etc. (Specify)	,		City or Town,	State)	
	To the Hospitei or At within 24 hours efter or To the Funerel Directompletely fitted in by	cal	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my know	viedge, death	occurred at the time	e, date and place	, and due to the cau	se(s) and manner as	stated.
	the H nin 24 the F nplete	tedical	one)	ner: On the basis of examinat and manner stated.	on and/or in	vestigation, in my of	olnion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	230. 11		29c. License	number	290 A	I. Date signed (Month	, Day, Year)
,	1		Caul U La	UM.C	· · · · · · · ·		() '		une a	200
	U		29b. Signature and title of certifier 30. Name and address of person who common Polyproma 31. Date filed (Month Pan Yearly 20)	empieted cause of death (Item	123a) (Tybe,	Printe du to	100 €	11 weeks	4 ND 21	224
ġ.	Sta	te	31. Date filed (Month, Pan Yearly ?)	32 Amaistrar's Signat	de de	Market 1				
	Registr	ar	JUNATE	1	-					

			1 - For State Registrar	e of Maryland / Department of Health and N Certificate of Death	Mental Hygier	- Z 11116 - Z 11115 II
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) MICHAEL JULION 4a. Facility Name (If not institution, give street and	St- Hot 1201 Hajustowa	John 10	Day Year 3. Time of Death OS 74M 4c. County of Death WESKINSTON
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	ar) 9. Birthplace (State or Foreign Country) (949
	the Maryland 28a-f show	Director	10a. State 10b. County Was Linish	10c. City, Town or Location 11 a S & S town, M.) 10f. Zip Code	2/740	10d. Inside City Limits 1 ☑ ¥es 2 ☐ No Citizen of What Country?
36	72 hours effer deeth with the Maryland natural', or Itams 23a or 28a-f show dical Examinar must be rodified at	by Funeral Di	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. un K13. Was Decedent of Hispanic Origin? (St d Forces? es 2 No	(14. Race - American Indian, Black, White, etc. Specify: Why te
21215-0036	J within plene. r than	Completed	15. Decedent's Education (Specify only highest grade complete	(ed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king unk 16b.	. Kind of Business/Industry unk
Maryland	e d is b	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
Baltimore, Mai	is 1 and 2 of Heelth a Item 27 is		19a. Informant's Name/Relationship (Type, Print) Washington County Po 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from the print of the p	20b. Place of Disposition (Name of		y or Town, State, Zip Code) unk Location - City or Town, State
Balti	permit. Pege Depertment of Important; If any Injury or once.		21 Signature of Fig. 1915 type Licens	Director State Anatomy Board Baltimore, MD 2120		altimore Street
8760,	Physician be executed by Manager and the settled by	icai Examiner	shock, or pearl failure. Listfonly one cause of immediate Cause (Final disease or condition resulting in death) Due Dequentially not currently failure and in the cause. Enter Underlying Cause. Disease or injury that initiated events C.	natical sed the death. Do not enter the mode of dying, such as cardiac on each line. A Linica A Land Circle Cunding to (or as a consequence of): It to (or as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death
.O. Box 6	y th	Physician/Medical	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death 3 Ectopic pregnancy regnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
rds, P	es pe	by	Part II. Dther significant conditions contributing to	to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	The ste h page	Completed			24a. Was an autopsy performed?	
	S S D	ation; To Be		Other	th Check onl one ome 5 Describe how in	
Division	2 \$ £ C	Certification:	3 Suicide 6 Could not be	lace of Injury - At home, farm, street, factory, office uilding, etc. (Specify)	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in the Indian In	edical ((Check only 2 Medical Examiner: On the	the best of my knowledge, death occurred at the time, date and place, the basis of examination and/or investigation, in my opinion, death occur nanner stated.	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number 7 1062	Ju	Date signed (Month, Day, Year) LN2 20, 2006
_				enue ac Hogenstown 1	40 217	42
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 2006	2. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Hortense Barto June 2006 10:40p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7200 Third Avenue(Fairhaven Nursing) Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F 99 578-01-9633 Director PA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumetic event, the Medical Examinar must be notified at Md Carroll Sykesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic event, the once. legal secretary 1aw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter M Bane Corilla Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Dowboro Rd., Pittsfield, NH 03263 John W. Barto (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 6-25-06 Sykesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Hought Sperbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Star Alzheimer's dementia end-Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to, as a consequence of, Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical esn IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31 DOOSGOSY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Hvenue 501 350 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Myron Alan Buchanan

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 20052

		- For State legistrar				Cert	ificate o	t L	eath)				F	Reg. N	O.	00	-	
Physician dical Examine	ician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year June 21, 2006 3. Time of Death 1902 hrs																	
	1	4a. Facility Name (if not institution Rt 152 northbound at		street and nu	ımber)				City, Tow Joppa	n, or Lo	ocation of	Death		ľ	4c. County Harford	of Death	1	
Funeral	1	5. Social Security Number	6. Sex		7. Age	e (In yrs. las	st birthday)		If Under 1	Year	If Under		8. Date of B	irth (MI	M/DD/YYY			tate or
Director		213-19-9815	1 X	M 2 F		25	Yr	s.	Months	Days	Hours	Min.	Dec.	9,	1980	Foreig Co	on Juntry) M a	aryland
any	_	Usual Residence of Decedent 10a. State 10b. County				10c. City. T	own or Loca	ation									10d. Insi	de City Limits
*	1	Maryland Harf	ord				ppa										1Y	es 2 X No
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ith the 1 23a or notified		500 Dembytown	Rd.				Lieu		2108					US				0.
or items 23		11. Marital Status 1 X Never Married 2 M	arried	12. Was Dec	orces?				Decedent , specify (cify Yes or N ican, etc.)	0-		e - Amer e, etc.	ican Indiar	n, Black.
s after de rral", or niner my		3 Widowed 4 Div	orced	1 Yes If Yes, Give Yes		_XNo	1	Y	es 2	No	specify:				Specify:	Bla	.ck	
hours after "natural"; Examiner	3	15. Decedent's Education (Spe	cify onl				16a. Decede during i		Usual Oc t of workin					16b	Kind of Bu	usiness/	Industry	
5-0036 ed within 72 hours after bygiene. other than "natural", the Medical Examiner	2	Elementary/Secondary (0-12)		College (1-4 or 5	o +)	Servi	C	э Тос	hni	cian				Cable	സ്ലി	evisi	ion
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	3	17. Father's Name (First, Middle	Last)	-			DCT V		2 100			Name (F	ırst, Mıddle,				C V 101	1011
2121 uld be fil Mental B marked c event,		Philip Alexand			an	_	19h Maili	na A	ddraee				enise ral Route Nu			n State	Zin Code	N
MD 2 d 2 shoul lth and N n 27 is m	-	Sheila Denise			Mo	ther	500 I				_		pa, Ma		•			;)
imore, MD 21215 Pages I and 2 should be filt ment of Health and Mental H ant: If item 27 is marked or or other tranmatic event, if	t	20a. Method of Disposition 1 X 8urial 2 Cremation				20b. Pl	lace of Dispo	ositio	on (Name				Date		c. Location			te
Pages ent of int: 1		4 Donation 5 Other S	pecify:		OIII Sta	ale l	ernac]	le	U.M.	Ch	urch	06-	29 – 06	Fa	allsto	on,	Mary]	Land
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tr		21. Signature of Funeral Service	Licens	see			22	Nar C	ne and Ad	dress c	of Facility nera	l Ho	me, P. Abino	Ą.	26	7	. 7 01	000
Physician	+	23a. Part I. Enter the disease, or			caused	the death. I	Do not enter	the	mode of o	esb lying, s	ury I uch as ca	rdiac or r	AD1no espiratory a	rest, s	hock, or he	cy±a art	Approx	imate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		ch line. Multiple In ,	juries												8etwee	en Onset and Death
zxammer :		or condition resulting in death)	-	oue to (or as	a conse	equence of)	:						,					
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rtificate be executed ing physician and as the burial - transit		UNPENDED		AMENDED														
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Box 6 e death ce the attend ed for use	312		known	4 Preg		time of dea	ath 5 (Othe	er (Specify	')								
P.O. Box 61 that the death cert med by the attendir detached for use a		Part II. Other significant condi	tions			h but not re	sulting in the	unc	derlying ca	iuse giv	en in Par	t I.	23e. Did	tobacc	co use conti	ribute to	the cause	of death?
S, P.O.	2																-	Unknown
ords aw requas beer	ompieted												24a Was					ings available of cause of
Rec The l	5											01 1	1 🗸 Yes		No 1	Y	es	2 No
ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	e e	25. Was case referred to medic examiner? 1 ✓ Yes 2 No		lospital: 1	Inpatie	ent 2	ER/Outpatie	nt		10	of Death (0		Home 5	Resi	dence 6	✓ Othe	r: Scene	
of \officers	- 1	27 Manner of Death		28a. Date	of Inju	ury 'ear)	28b. Time o	f Inju	ury 28		at Work?	IS	8d Describe				in vehic	ular
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3		30. Name and address of person Theodore King MD.		istant Med				en	n Stree	t, Balt	imore, l	MD 21	201					
Sta		31. Date filed (Month, Day, Year	7 20		egistra	ar's Signatui	re	, -										
Registr		0011 2	20	UO L	S. So	war of	7	34	K)									
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			1 - For State Registrar	State of Maryla			of Health a			giene Reg. No.	2006	20053
			1. Decedent's Name (First, Middle, Last)				1	2. Date of De	ath		3. Time of Death
	Physici		ERNST BAN	USE JR.					Month	Z4	7006	20:53 M
1	/Medio Examin		4a. Facility Name (If not institution, give			4b. City. To	own, or Location	of Death	06		ounty of Death	20.23
1	Exami	iei	()	Lad Alaka	1 (.)	0					1timore	City
	Funaval	1.50	5. Social Security Number 6. Se	x* 7. Age (In v	rs. last birthday)	If Under 1	Year If Under		8. Date of Bir			
	Funeral Director		223-86-9573	M 2□F 51	Yrs.	Months	Days Hours	Min.	8. Date of Bir (Month, Da 02/17/		NE Cour	place (State or Foreign ntry)
			Usual Residence of Decedent	31				1	02/1//	1900		
	ylen		10a. State 10b. County	10c.	City, Town or Lo	ocation					1	0d. Inside City Limits
	Mar	tor	MD Anne Aru	nde1	Hanovei	c						1 ☐ Yes 21 No
	7.284	rec	10e. Street and Number			10f. Zip C	ode			10g. Citize	on of What Cour	ntry?
	3a o	ā	7205 Linda Avenue	2		2	21076			II	S.A.	
	deat	by Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		nt of Hispanic Ori Cuban, Mexican	igin? (Spe	cify Yes or No		Race - Americ	
ယ	or its	Ē	1 ☐ Never Married 2X Married	Armed Forces? 1 No 2 □ No					rican, etc.)		Black, White,	
ଞ୍ଚ	E. E.	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 218	No Specify:			S	pecify: wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23e or 28e-f ehow he Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			dent's Usual (Occupation done during mos	et of workin		16b. Kind	of Business/In	dustry
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g	e filed al Hygie Fother vent, E	Be (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle.	Maiden S	umame)	
<u>a</u>	Vid b Menti rked rked	To	Ernst John Banse,	Sr.			J	oanne	M. Sa	nders	on	
a	2 should be i and Mental I ie marked o reumatic eve		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (S	Street and Numbe	er or Rural	Route Number	er, City or T	Town, State, Zip	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylen if Health and Mental Hygiene. Item 27 is marked other than "neturet", or iteme 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at		Mrs. Karen Banse	/ wife	72	.05 Lin	ıda Avenı	ue: H	anover	, MD	21076	
Baltimore,	ten oth		20a. Method of Disposition	208	b. Place of Dispo cemetery, crei	osition (Name	of er place)	Da	ate	20c. Loca	ation - City or To	own, State
Ĕ	Page Mant of Mart: M		1 ☐ Burial 2 ②Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	•	-	mation	06/27	7/2006	Star	zanewi 1	lo MD
Ħ	permit. Pages I Department of H Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Licens		22	2. Name and	Address of Facili	y Sin	oleton	Fune	ral Hom	o DA
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			23a. Part1. Inter the disease, or compl	ications that caused the d							2100	Approximate
			shock, & heart failure. List only of Immediate Cause (Final	ne cause on each line.		0						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		awal c	of co	272					
	Examiner			Due to (or as a cons	sequence of):		0					
		_	Sequentially list conditions,	Due to for as a cons	arcin	ono	of co	000				
	E WE	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 to (5) 45 4 50 ii	496.0							
	and and	Examiner	that initiated events resulting in death) Last	Due to (or as a cons		00515						
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87	cate phys	dical		Childs		irch	05:5					
× e		Physician/Med	IF FEMALE:	3c. If yes, outcome of pre	anana.							
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	Ectopic preg				23	d. Date of delive Month	ory Day Year
o	thet the death certificated by the attending detached for use es	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	of death 5	Other (spec	rify)					,
<u>о</u> .	d by fetac	Ph	Part II. Other significant conditions con	stributing to dooth but out	rogultina in the				OZa Dida			ne cause of death?
Ś	8 5 8	Š	Part II. Other significant conditions con	ambuting to death but not	resulting in the o	nderlying cau	se given in Part i					
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<u> </u>		Ö							perfo	rmed? 2D No	death?	2□ No
<u> </u>	Physician: The lav this certificate has al director, page 2	Bec	25. Was case referred to medical				26. Place	of Death	(Check only o	1		
>	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nu	ursing Hom	e 5 🗆 Resid	ience 6 [☐Other (Specif)	w)
Division of Vital Record			27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of	f 28c	. Injury at Work?		Bd. Describe h			
<u>ō</u>	Attending r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Bay 10al	, inquiy	М	1 Yes 2	No				
<u> </u>	ar de ecto by th	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - A	t home, farm, str	eet, factory, c	office	21	Bf. Location (S	Street and I	Number or Rura	I Route Number,
ā	s afte	Certification:	4 [Homolog	building, etc. (Spe	эспу)				City or Tou	m, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my i	knowladge deat	i securist at	the three, date an	id place, at	nd dua to the	tause(s) ar	nd manner as st	ated.
	24 P.	edical	(Check only 2 Medical Exami one)	ner: On the basis of exam and manner stated.	ination and/or in	vestigation, in	my opinion, dea	th occurre	d at the time,	date and pl	lace, and due to	the cause(s)
	To the Yithin 2 To the complet	Me	29b. Signature and title of certifier			29c. L	icense number			29d. Date s	signed (Month,	Day, Year)
		7 1	1 Call			1	FPFD			06	17412	006
	di		30. Name and address of person who co	ompleted cause of death (I	tem 23a) /Type		- 1 1 1				10-110	~~6
	1		Rishi R. Cupto	00 .	Green		2-1	h	ore,		210	
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Sig	gnature	J1.	Sect	17 10-16	16	~ 10	212	54_
F	Registr		JUN 2 7 2006	02. Registrar's Sig	7 9084	as of						

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		•	For State Registrar	Glate of Mi		ertificate of		_	Reg. No. 200	6 2005
	Physici	an	Decedent's Name (First Middle	, Last) RRW	Bai	eley		2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution		700	0	r Location of Death	JUNE	22 3000 4c. County of Dea	15:11 AM
	LX		SINAI HOSPITAL O				MORE		NI	A
	Funeral Director		5. Social Security Number 217-38-9420 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da (Morch	th y, Year) 9. 8ir 4 (946 V	thplace (State or Foreign ountry)
	Maryland -f ehow	tor	10a. State 10b. County	NIA	10c. City, Town or	Location 2	more)		10d. Inside Ofty Limits 1 ☑ Yes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number	Tion Ave		10f. Zip Code	1216		10g. Citizen of What Co	ountry?
2-003p	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28e-f ehow he Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 Tyes 2 If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - Ame Black, Whi Specify:	
	72 hours natural',	eted	15. Decedent (Specify only highes	s Education t grade completed)	16a. De	cedent's Usual Occup ve kind of work done o. DO NOT use retired	nation during most of work	king	16b. Kind of Business	/Industry
717	permit. Pages 1 end 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natur any njury or other traumatic event, the Madical ADGS.	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+) life	DO NOT use retired	rR		Circu Maiden Sumame)	Try Club
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2	nd 2 sh lth and 27 is m		19a. Informant's Name/Relations!	Ip (Type, Print)	Fe 64		- 4	0	to md.	•
Dalumore,	ages 1 end 2 ent of Health ett: if Item 27 i y or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		20b. Place of Discemetery, of	position (Name of rematory or other place		Date 9-06	20c. Location - City or	
0	permit. Pag Department Important: i any njury c		21. Signature neral Service			22 Name and Addre	ss of Pacility 2	70 Fee	AITILTUN P	ass
מ	Per Dep		220 Bary Establishment of	homelications that cause	I the death Do not	Sang P	· march			Approximate
3	Physician		23a. Part F a the disease or shock r lear failure. List Immediate ause (Final disease or ondition resulting in death)		TI - ORGI			ECONDI		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequence of):	u Rowe	03	TOUR	TUAC	7 days
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Ď	tificate be executed g physicien and es the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
00/00	cate be physicia the bu	edicai		d						
P.O. Box o	Attending Physician: The law requires that the death certific relath. setor: After this certificate has been signed by the ettending is the funeral director, page 2 should be detached for use es	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	1		23d. Date of de Month	livery Day Year
7	s that if	y Ph	Part II. Other significant condition	ns contributing to death t	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did t	obacco use contribute to	o the cause of death?
ő	w require been sig should b	ted b	DIABETES		ENSCON	COROL	AKY	10'	Yes 2011 No. 3□P	robably 4 [Unknown
Hecc	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed	ARTERY	DISEASE				24a. Was autor perfo 1 \(\text{Yes} \)	osy prior to death?	utopsy findings available completion of cause of
<u> </u>	sician: certific irector.	Be	25. Was case referred to medical examiner?	Hospital:	2 T S D (0	i all post Oth	26. Place of Dea			
200	ing Phy After this uneral d	on: To	27. Manner of Death 1 Natural 5 □ Pendin			o of 28c. Injur	y at k?		dence 6 Other (Spenow injury occurred	ecny)
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funerei Director: A completely filled in by the fu	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	et be	ury - At home, farm, c. (Specify)		Yes 2 □No	28f. Location (Street and Number or R wn, State)	ural Route Number,
	Hospital 24 hours a Funerei I stely filled	Medical Ce	29a. Certifier 1 Lertiyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner st	f examination and/or	eth occurred at the tin investigation, in my o	me, date and poet	and due to the red at the time,	causa(s) and manner and date and place, and due	s etated e to the cause(s)
\	To the within To the comple	Me	29b. Signature and title of certifier		0/ 00.	29c. Licens		500	29d. Date signed (Mont	
	9		30. Name and address of person,	an Au		e. Print)	D0063	2 00	Jun 22	, 2006
400	01		31. Date filed (Month, Day, Year)	SPITAL of	BALT (MORE				
	St Regist	ate rar	JUN 2		-	1 4				
DH	MH 17 Rev 1/2	001		7 2006	67	GINAL				
					ORI:	IAVIIL				

			1- For Amend Item 23a per dr., G	856,066	rtment of Health a 27706dhb tificate of Death	nd Mental Hyg	giene 2006	20055
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Philip Matthew Buzzuro				3, 2006	6:00 P ^M
	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Deatl	h
			6 Deepwater Ct. Apt. M		Cockeysvil	le	Baltin	
	Funeral		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs	. last birthday) .4 Yrs.	Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day March I	Year) 9. Birti	nplace (State or Foreign untry) ryland
	Director		Usual Residence of Decedent	4		rarch 1	0,1902 Ha	Lyland
	land ow			ity, Town or Lo	cation			10d. Inside City Limits
	Many if sh	ţō	MD Baltimore	Cocke	eysville			1 □Yes 2X No
	r 28s	Director	10e. Street and Number		10f. Zip Code		log. Citizen of What Co	untry?
	h with	a D	6 Deepwater Ct. Apt. M		21030		USA	
	ours after death with the Marylan rel', or Items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in 1 Armed Forces?	J.S. 13.	Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
9	or Ite	F	1 ሺ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No ☐ If Yes, Give		I ☐ Yes 2 ☑ No Specify:		Specify: Wh	-
8	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show dical Examiner must be molified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	140. 0	1.3.11.10			
7		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/l	maustry
12	d within giene. r then "	шć	Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A	Engi	neer Technicia	n	Construct	ion
9	a the first		17. Father's Name (First, Middle, Last)			's Name (First, Middle,	Maiden Sumame)	· · · · · · · · · · · · · · · · · · ·
Maryland 21215-0036	Q 00 0	To Be	Philip A. Buzzuro			Yvonne DeL	eon	
ary	2 should and Men is marke reumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Number	or Rural Route Numbe	r, City or Town, State, Z	(ip Code)
Σ	is 1 and 2 should by Health and Menitem 27 is market other treumatic		Yvonne D. Buzzuro/Mother	1419	Burton Ave.	Lutherville	, MD 21093	
Jre			20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State	Place of Dispo cemetery, crer	sition (Name of natory or other place)	une 14,	20c. Location - City or	Town, State
Ĕ	nit. Pages artment of ortant: If it injury or o				ematory	2006	Baltimore	
Baltimore,	permit. Page Department Important: If any injury or		21. Signature of Funeral Sence bicensee Michael J. Flagl	.e 10	Name and Address of Facility Emmon Funeral D W. Padonai Ro	Home of Dul Dad Timoniu	aney Valley m. MD 21093	, Inc.
			23a. Part1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician	3 (Diabet	es Mellitus			Onset and Death
	/Medical	1	resulting in death) Due to (or as a conse					
	Examiner		Sequentially list conditions b.					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quarios of):				
	and P-trans	Examin	that initiated events resulting in death) Last Due to (or as a conse	quence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transitions.	四田	Type	DIAC	THE .		4	38 years
687	cate b	dical	d. 1772	DINO	. 18-3			
Box (leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant				23d. Date of deli	very
-	death e atte d for	icial	in the past 12 months? 1 Ves 2 No.		Ectopic pregnancy Other (specify)		Month	Day Year
P.O.	at the de by the tached	hys	9 ☐ Unknown					
	res tha igned be det	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	
ğ	w require been sig should b	ed					es 2□No 3□Pro	obably 4 Unknown
of Vital Records,	e law re has be je 2 sho	Completed				24a. Was a autop	sv prior to d	topsy findings available completion of cause of
Ä		, mo				perfor	med? death?	2□ No
ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			of Death (Check only or	76)	
× ×	Physicien: this certific ral director,	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier			ence 6 Other (Spec	cify)
ū	ing P	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?		ow injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of logue At	hama farm at	M 1 Yes 2 N		treet and Number or Ru	ral Route Number
Division	or At after Direc in by	Certification;	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	nome, tarm, str eify)	eet, factory, office	City or Tow		rai rioute riumber,
	pitel burs a lerel filled		29a. Certifier 1 Certifying Physician: To the best of my kr	nowledge, deat	n occurred at the time, date and	place, and due to the o	ause(s) and manner as	stated.
	24 h 24 h 9 Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examinations)					
	To the Hospitel or Attending Phy within Z4 hours after death. To the Funerel Director: After thi completely filled in by the funeral to	Me	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Month	n, Day, Year)
)	->-0		1 (Post Vi	3	D2930	7	6/14/00	
			30. Name and address of person who completed cause of death (Ite	em 23a) (Typ <u>a</u>	Print)		,	
	10		ROSEMARY OLIVO M	> 3	DOI ST. PAUL	PL. E3	12 BURK	BUILDING
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	1		BALTIM	BUILDING LORE, HD 21202
	Regist	rar	JUN 2 7 2006 Deserve	J. A.	Davie			51307

Please Type or Print in Black Indelible Jak. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 7:00 AM JUNE AN /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE MARI IMONIUM LUIHERVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Months 217-91-6433 Usual Residence of Decedent Yrs. Director MAR with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? TIMORE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 PNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 NWidowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "any Injury or other treumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) OHIGRADE SABL CITY OF BALTIHORE ED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GRIFF ANNIE 2 -LIAM 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MOTHERY 2410 W. FRANKLIN ST. ANNIE GRIFFIN BALTIHORE, MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State CREMATORY 06-28-06 BALTIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility BROWN JR. FUNERAL HOME JOSEPH H. BROWN BRITHER AL HOME 21. Signature of Funeral Service Licensee JOSEPH H BALTIHORE, TON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACQUIRED IMMUNE DEFICIENCY SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2□ No 1 Yes 2 No 1 Tyes or Attending Physician: : After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Certification; To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 106 6/22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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	1	For State Registrer		State o	f Mary			nent of Ficate of			lental Hy	giene Reg. No.	(L U	06	20057
	1	. Decedent's Name (First,	Middle, Last)								2. Date of De	ath Day	,	Year	3. Time of Death
Physician /Medical		SIELLI	9 B	sun	ME1	STEL					06	2	3	06	2130 M
Examiner		a. Facility Name (If not in					4b	. City, Town, o		of Death			County		
	5	Atlantic Ge . Social Security Number	eneral 6.Sex			yrs. last birti	hday) If	Berli Under 1 Year		er 24 Hrs.	8. Date of Bir			ster 9. Birthpl	ace (State or Foreign
Funeral Director		216-09-839	4.5	м 2[X F	86		rs. Me	onths Days	Hours	Min.	8. Date of Bir (Month, Da Oct. 2	2,19	19	Mo	ace (State or Foreign try) C.
	}	Jsual Residence of Deced			10	c. City, Town	or Locativ							14	Od. Inside City Limits
arylar			County Vorcest	er	100	Ber.		311							1 □ Yes 2 X No
ior 286-fel	5	Oe. Street and Number					1	Of. Zip Code				10g. Cit	izen of V	/hat Coun	try?
3s or		4 Waterton	wn Rd.					21811					USA	Δ	
officer death value of the result of the res	5	11. Marital Status		12. Was Dec		r in U.S.	13. Was	Decedent of H	Hispanic C	origin? (Spe	ecify Yes or No Rican, etc.)	D-		- Americ k, White,	
336 urs after or, or ite	2	1 Never Married 2		1 ☐ Yes If Yes, G	2 X No			Yes 2X No					Specify	Whi	te
hours ture!		3 X Widowed 4 □ D	ecedent's Edu	Year or C	Dates:	16a.	Decedent	's Usual Occup	pation	-		16b. K	ind of Bu	siness/Inc	dustry
21215-00 ed within 72 hor vgjene. Per then "neturn it, the Medical Et, the Med	-	(Specify only	/ highest grad	e completed)	1-4or 5+)			of work done NOT use retire	during mo ed)	ost of work	ing				
212 ad with giene er the	5	8 yrs.					House	ewife	T				Home		
Maryland 21215-0036 to 2 should be illed within 72 hours att the and Mental Hygiene. 27 Is marked other then "neturel", or rireumatic event, ille Medical Exart To Re Completed by F	ם ם	17. Father's Name (First,									e (First, Middle Adamski		Sumam	e)	
ryla nould hen marke natic		Paul Kai	minski _{Plationship} (Ti	ine Print)		19b	Mailing A	ddress (Street			al Route Numb		or Town.	State, Zip	Code)
Ma id 2 sl ith an 27 is r		Roger Buri			n		3				n Md. 2				
S 1 ar it Head item?	7	20a. Method of Disposition				20b. Place of cemeter	Disposition y, cremato	n (Name of ary or other pla	ace)	June	Date 29	20c. L	ocation -	City or To	wn, State
Page nent o		1 X Burial 2 ☐ Crer 1 4 ☐ Donation 5 ☐ C			State	Meadov	vridg	e Cem.			2006	E	lkri	dge	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23s or 28e-1 ehow any injury or other treumatic event, if a Modical Examinational process. To Be Completed by Funeral Director		2 Signature of Fineral S	Service Licens	••			22. No Conr 7110	ame and Addre	unera unera	al Ho	me Of D Rd. 212	unda 222	alk		
	+	23a. Part J. Enter the dise	ease, or comp	lications that	caused the	death. Do r	ot enter t	ne mode of dyi	ing, such a	as cardiac	or respiratory a	arrest,			Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	To: Elocomy o	CE	non	NARY	AR	TZM-	Y D	ISEA	152			ł	Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as a co	onsequence	of):								
£ 72 E E E E E		Esquentially flet condition	10	b	(or as a co	onsequence	of):								
3/2006 9 9/2006 9 executed in and inal-transit	TILLE	Esquentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	₹		(4: 41										
3, Co exec		that initiated events resulting in death) Last	- 1	Due to	(or as a co	onsequence	of):	-							
16/12/6/18/6/18/6/6/6/6/6/6/6/6/6/6/6/6/6/6/6	Sa			d											
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DOB DOS 68 BOX 68 Heath certific	Physician/we	23b. Was decedent preginthe past 12 month	nant	1 Live		∃Fetal death		topic pregnanc	су				Mo		Day Year
the de sached	JSIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk											
ds, P.O. ires that the dissipned by the defeached	Dy Pr	Part II. Other significant	conditions co	ntributing to	death but n	ot resulting in	the unde	rlying cause gi	iven in Pa	rt I.					ne cause of death?
76/5											1 🗆	Yes 2	! □ No	3 Prob	pably 4 Unknown
17 Do B 10 S PC Do B 10 S P 10 S P 10 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P	Completed										24a. Was	s an opsy ormed?	- 1	Were auto prior to co death?	psy findings available mpletion of cause of
			r								1 ☐ Yes	2 Z N		Yes	2 No
Vitt Sicien	o Re	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No	-	Hospital:	d'Innationt	2□ER/Ot	tnotiont	2C DOA 0t			th <i>(Check only</i> ome 5 ☐ Res		6 □Oth	er (Snecit	iv)
P. C. p. yar and a salah	-	27. Manner of Death			e of Injury onth, Day Y		Time of	28c. Inju		rear sing re	28d. Describe				,,
ion nding ath. r: Afte	atio	2 Accident	Pending investigation		mui, Day T	6 <i>ai)</i>	njury		∏Yes 2	□No					
StellA J. But Division of Vita Division of Vita Division of Vita Division of Vita Within 24 hours after death. To the Sunarel Director. After this certific completely filled in by the tuneral director.	Certification:	3 Suicide 6 C	Could not be determined	200. Flat	ce of Injury ding, etc. (- At home, fa Specify)	ırm, street	, factory, office	9		28f. Location City or To	(Street a. own, Stat	nd Numb e)	er or Rura	al Route Number,
St.		29a. Certifier 1	Certifying Ph	veicien: To ti	he hest of n	ny kaowledou	death or	coursed at the t	time date	and place.	, and due to the	a cause(s	s) and ma	inner as s	tated.
Hos 24 hos Funn etely	edicai	(Check only 2	Medicel Exem	iner: On the	basis of ex	camination ar	d/or inves	tigation, in my	opinion, o	leath occur	rred at the time	, date an	d place,	and due to	the cause(s)
To the within To the compl	Me	29b. Signature and title of	of certifier					29c. Licen	nse numbe	er	_	29d. Da	ate signe	d (Month.	Day, Year)
		4) LA				_	100	050	1821	6	01	6/2	3/0	6 2145
4		30. Name and address of	f person who	completed ca	use of deat	th (Item 23a)	(Type, Pri	En Ch	was	Dr	B26	19	mi	2	-1811
State	e	31. Date filed (Month, Da	ay, Year)		Registrar's	Signature	- 1/	1	(
Registra	iŕ	JUN 2	7 2006	More	Re ,	1. B	DBALL	,							

		4	For State Registrar	State of Mi	aryland /	Certifica				Reg. No.	Ub	20028
	Physicia		1. Decedent's Name (First, Middle, L		2112				2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi		ZVINS		tv. Town, or	Location of Death	JUNE	23 a	of Death	9:40 PM
	Examin	er	Baltimore washin		cal Cent			Burnie		And	ie A	rundel
H	Funeral Director		5. Social Security Number 6. 217 56 4421	Sex 7. Ag 1 ⊠ M 2 ☐ F	e (In yrs. last bi	Yrs. If Und Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug • 2	th Year) 8, 1950	9. Birthp	lace (State or Foreign try) y Land
	and w	.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location					1	0d. Inside City Limits
	Mary -f ehc	tor	Maryland Anne A	rundel	0de	nton						1 ☐ Yes 2] No
:	th with the 23a or 28i	al Director	10e. Street and Number 488 N. Patuxe	nt Road L	ot 5		Zip Code 211			10g. Citizen of U.S		ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Heatil and Mental Hygiene. Deperment of Heatil and Mental Hygiene. Important: If time 72 is marked other then "neture", or iteme 23a or 28a-f show eny injury or other traumatic event, the Mandred Examiner must be notified at angle. BARCE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ② If Yes, Give Year or Dates:			cedent of Hi pecify Cuba 2 A No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes o <i>r</i> No o Rican, etc.)		ce - Americ ck, White, y: Whi	etc.
Baltimore, Maryland 21215-0036	rithin 72 ho ne. hen "netur M. dical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or	54)	Decedent's U (Give kind of life. DO NOT	work done d use retired	ation during most of wor))	kıng	16b. Kind of B		dustry
d 2	filed w Hygier ther ti	CO	12th 17. Father's Name (First, Middle, Las	st)				18. Mother's Nan	ne (First, Middle			
an	lid be fental rked o	To Be	Pau1	Blevins				Mar	y Hios			
Mary	nd 2 shot alth and N 27 is main		19a. Informant's Name/Relationship Pauletta Blevir					and Number or Ru nt Road 1				Code) land 21113
more,	Pages 1 and 2 nent of Health a int: if item 27 is iry or other tra		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donatjor 5 Other (Spec		20b. Place cemete Loudor	of Disposition (f ery, crematory of n Park (Cemete	ery 6/28	Date 3/2006		ore, l	Maryland
Balti	permit. Depertmine imports eny inju		21. Signature of Juneral Serve Lio	×1500	,	22. Name	and Addres	s of Facility	once Fu			e, P.A. land 21225
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each !	d the death. Do	not enter the m	node of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
) [Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	ON GC	5700	HE-	17,25	FAILU	in		
	Examiner		Sequentially list conditions.	t. Co	W CONT	DLOCE	5	O. Benz	5 MEZ	citus		
J	nsit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):	2501	PHAL	0 2-	-Viii		
. ,09	tificate be executed ig physicien and as the burial-transit	al Exa	resulting in death) Last	Due to (or as	a consequence	of):		7777	, , , ,	7.7	I	
68760,	ificate g physi as the l	edlcal		d								
	ath cert stendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		of pregnancy 2 Petal deat It time of death	h 3 □Ectopio 5 □ Other	pregnancy (specify)				ite of delive onth	ery Day Year
ds, P.O.	iuires that the de signed by the e	ρ	Part II. Other significant conditions	contributing to death I	out not resulting	in the underlyin	g cause give	en in Part I.		tobacco use con Yes 2 □ No		ne cause of death?
Vital Records,	The law requir ete has been si pege 2 should	Completed). 								prior to con death?	psy findings available impletion of cause of
		Be C	25. Was case referred to medical examiner?					26. Place of Dea				
ō	Phys this ral di	မှ	1 ☐ Yes 2 ☐ No 27. Manney of Death	Hospital: 1 Inpati		outpatient 3 Time of	DOA Othe	4 🗀 Nursing F		idence 6 Dott		y)
	ing After une	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay Year)	Injury M	Worl	k? Yes 2 □ No	200, 200, 20			
Division	- 0 -	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of in	jury - At home, tc. (Specify)	farm, street, fac	lory, office			Street and Num wn, State)	ber or Rura	ti Route Number,
	he Hospital or n 24 hours afte he Funeral Dir pletely filled in I	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination a	ge, death occurr ind/or investigat	red at the timition, in my of	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and m date and place,	anner as s	tated, the cause(s)
1	To the Hosi within 24 ho To the Fund completely f	Me	29b. Signature and title of centrier				29c. Licenso			29d. Date signe	•	
				completed	death (to-) (T - 2 : :)	1)0	0557	- 3	June 2	3, 6	2006.
	10		30. Name and address of reson we Dr. Daljeet Sid	hu 208 C	rain Hig		W.	Glen Bur	nie, Ma	ryland 2	1061	4.73
ď	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	Regist	trar's Signature	boute	,					

Bievins, Paul

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician IUNE 705 AM Dorothy **Blizzard** 2006 Isabella /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PITY BALTIMORE BALTIMORE OSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Months Hours Davs 1 ☐ M 2 🖾 F Yrs. 217-28-6521 Aug. 30, 1932 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle item 27 le marked other then "natural", or items 23a or 28a-f ebov other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No MD Carro11 Hampstead Direct 10g. Citizen of What Country? 10e. Street and Number 21074 4484 Woodsman Drive Unite 1322 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Hilda Marie Bowersox Truman Ray Lindsay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6134 Glen Falls Road Reisterstown , MD Vicki Locklear (Daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₹ = 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Park 6/29/06 Finksburg, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road And ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE MYOCARDIAL INFARCTION Immediate Cause (Final day Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ARTERV 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE 24a. Was an autopsy performed2 RENAL CHRONIC 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -JUNE 24, 2006 D0063500 MD PhD address of person who completed cause of death (Item 23a) (Type, Print) Christian Minshall BALTIMORE 32. Registrar's Signature 31. Date filed (Mq 77 2006 State Registrar

BLIZZAKD, DOROTHS

				1 - For State of Ma	aryland /	Departme Certific			ind M	ental Hy	giene Reg. No	2006	20060
		Physici	20	Decedent's Name (First, Middle, Last)		DAED				2. Date of De	eath		3. Time of Death
		/Medic	cal	RITA		BAER	ih Tour o	r Location o	of Dogsth	JUNE		. County of Deat	5:00PM [™]
		Examir	ıer	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRI	ST CTR		illy, rown, o	TOWSC			40		IMORE
200		Funeral Director		276-28-1431 ¹□M 2\\F	74	oirthday) If Ur Yrs. Mont	hs Days	If Under a		8. Date of Bi	^{rth} 931	9. Birt Co	hplace (State or Foreign untry) OH
3		land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location							10d. Inside City Limits
0		ith the Marylar or 28a-1 ehow	tor	OH FRANKLIN	С	OLUMBUS							1 X Yes 2 ☐ No
Sune		>	Funeral Director	10e. Street and Number		10f.	Zip Code	43213			10g. Cit	tizen of What Co	untry? USA
5		death v	erai	822 OLD FARM ROAD 11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was De			gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - Ame	ncan Indian,
×	920	s 1 and 2 should be filed within 72 hours after death v I fleelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s other traumatic event, I're Medical Examiner musal.	by	Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	lo		specify Cuba s 2∰ No	an, Mexican Specify:	, Puerto I	Rican, etc.)		Black, White Specify:	e, etc. WHITE
S	5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedent's U	work done	durina most	of workii	ng	16b. K	ind of Business/	Industry
	Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other than sumatic event, I'm Ma	Completed	Elementary/Secondary (0-12) College (1-4or 5	+) H	iife. DO NO IOMEMAKE		2)			IWO	N HOME	
8	nd 2	al Hyg	BeC	17. Father's Name (First, Middle, Last)						(First, Middle	, Maiden	Sumame)	005540550
古	yla	d Ment d Ment narked natice	To.	BEN 19a. Informant's Name/Relationship (Type, Print)		NDAU	reso (Ctroat		ADIE	I Paula Mumb	or City	or Town, State, 2	GREENBERG
8	Z S	nd 2 sh pith and 27 le n r traun		MARCY BAER / DAUGHTER		O MINEB							up Code)
S. K.	ore,	es 1 and 2 of Heelth of Item 27 if ir other tre		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal from State	cemet	of Disposition (or other plac			ate		ocation - City or	
X	Baltimore	permit. Pages Department of I Important: if It any Injury or of		4 ☐ Donation 5 ☐ Other (Specify)	HILLT	OP SERV						TOWSON,	
<u>G</u>)	Bal	permit. Departr Imports any Inj.		21. Signature/di Funeral Service Licensee		8900	REIST	ERSTO	NN RO	DAD - F	PIKES	BROS.,	MD 21208
				23a. Part1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	10.		1	,			arrest,		Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death) Due to (or as	a consequenc	en cep	bung	-8 pm	The	7	, ,		CAYS
	ı	Examiner	L	Sequentially list conditions b. Can	deac	- A	ves7	W.	th	ressci	tatio	m	days
		nsit Age	Examiner	if any, leading to immediate Due to (or as cause. Enter Underlying Cause (Disease or injury		diAL	in	JAVO	tie	M			days
	oʻ	ate be executed hysicien and the burial-transit		that initiated events resulting in death) Last C. Due to (or as			7	4	•				04173
	8760,	ate be hysicie the bu	dlcai	d				Vi.					
	9	eath certific attending p for use as	/Mec	IF FEMALE: 23b. Was decedent pregnant		` -						23d. Date of del	ivery
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	S, D	es that gned b	by Pt	Part II. Other significant conditions contributing to death be	ut not resulting	g in the underlyi	ng cause giv	en in Part I.				_	the cause of death?
	ord	w requires that s been signed b should be det									Yes 2		obably 4 Unknown
	Division of Vital Records,	ding Physician: The law h. After this certificate has t funeral director, page 2 s	Completed							24a. Was auto perf 1 Yes	an psy ormed? 2 No	death?	topsy findings available completion of cause of 2 No
	Vita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?			Ott		-	(Check only			
	o	g Phys er this eral di	n; To	27. Manner of Death 28a. Date of Inju	nt 2 ER/C	. Time of	28c. Injui			ne 5 ☐ Res 28d. Describe		6 Other (Specified)	civ) Hospice
	sion	or Attending siter death. Director: After in by the fune	atio	2 Accident investigation		Injury M	10	Yes 2 □!					
	DİVİ	lor Atlefated Direct	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	ury - At home, c. (Specify)	farm, street, fa	ctory, office		2	28f. Location City or To	(Street ar wn, State	nd Number or Ru 9)	ral Route Number,
		To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best on the basis of and manner start.	examination a								
سر	V	To the vithin To the comple	Me				29c. Licens	e number	_	-	29d. Da	te signed (Monti	h, Day, Year)
				A Hothong lily	and	1	1)25	105			Ju	m23,	2006
		8		30. Name and address of person who person person who person pers	eath (Item 23a	a) (Type, Print)	Chon	les S	7.	Balt	o. M	d 212	04
		St Regist	ate	31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	to Spe	S.					ite signed (Monti M23, d2t2	

		1 - For State Registrar	State of Maryland		artment o				giene Reg. No.	006	200	61
Physic		Decedent's Name (First, Middle, Last) PAUL	Joseph		Ţ.	BUDR	.15	2. Date of De Month プロロモ	ath Day 24	Year 2006	3. Time of De 2220	
/Med Exami	ner	4a. Facility Name (If not institution, give si THE SCHAS HOPKINS 5 Social Security Number 16 Sex		ıst birthday) Yrs.	BALT If Under 1	i M o RE (ear If Unitary) Hou	C ₁ T Y	8. Date of Bir (Month, Da June 7.	th	Cou	place (State or F intry) SSachuse	
Director works !		Usual Residence of Decedent 10a. State 10b. County Pennsylvania Cent	10c. City	, Town or Lo	cation			oune 7.	1340		10d. Inside City	Limits
ith the or 28a	Direc	10e. Street and Number			10f. Zip Co					of What Cou		
within 72 hours after death with the Maryland sne. than "natural", or Itams 23s or 28s-1 show the Madical Examiner must be redilled at	by Funeral Director	314 Fairfield Drive 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates:	i		_		ecify Yes or No Rican, etc.)	14.	Race - Ameri Black, White Becify: W		
d within 72 hours aff giene. Br than "natural", or	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. :	dent's Usual C kind of work of DO NOT use i	done during r retired)		ang		of Business/Ir	ndustry	
the filed winter Hygien ed other the	Be	17. Father's Name (First, Middle, Last) JOSeph Budris	5+	_	Plant M		other's Nam	e (First, Middle	, <i>Maiden S</i> u	Paper mame)		
paritimities in the property of the control of the party	To.	19a. Informant's Name/Relationship (Type Frences K Budris 20a. Method of Disposition 1 □ Burial ★ 12 Cremation 3 □ Rel	Wife 20b. Pl	314 I	airfie	eld Dr	ive St	Date	lege 20c. Locar	Pennsy: tion - City or T	Ivania 1 own, State	
permit. Pages 1 a Department of Hee Important: If Item any injury or othe		Donation 5 Other (Specify) 2 signature of Funeral Service License	Uak			Address of Fa		7/06 chell-Wie d Baltimo	defeld	Funeral		sylv.
Physician /Medical Examinet sthe purial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	LOMA						Onset and De	
death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic preg				230	d. Date of deliv Month	very Day Ye	ar
	þ	Part II. Other significant conditions con		Ilting in the u	nderlying cau	se given in P	art I.		tobacco use Yes 2 1		the cause of dea	
The ate ha	Completed	HEPATIC FAIL	WRE					24a. Was auto perfo 1 Yes		24b. Were aut prior to co death? 1 ☐ Yes	opsy findings av ompletion of cau 252 No	allable ise of
Jor Attending Physician: T after death. Director: After this certificat in by the funeral director, pg	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify	ER/Outpatier 28b. Time of Injury me, farm, st	f 28c	Other: 4 Dilling At Work?	Nursing H	th Check only ome 5 Res 28d. Describe 28f. Location (City or To	dence 6 how injury of	occurred	ral Route Numbe	9r,
lospita t hours uneral	edicai Cer	(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat	wledge, deat								
To the P within 24 To the P complete	Med	one) 29b. Signature and title of certifier	and manner stated.	-	29c. l	icense numb	per		29d. Date s	igned (Month	, Day, Year)	
1 7		30. Name and address of person who co		23a) (Type,		5-00	0		June	24,2	206	
5 V Regis	tate	JAMES KIM MD JOHNS H 31. Date filed (Month, Day, Year) JUN 2 7 200	22 Degistratic Signal	600 is	GRIH WO:	efe ste	BET, BA	LTIMORE,	MARY	AND	21287	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 50 **Physician** BOWERS 22 TIEORGIE JUNE 2000 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKING BAYVIEW MEDICAL -CENTER BALTIMORE 7. Age (In yrs. last birthday) 83 B. Date of Birth
(Month, Day, Year)
July 20, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F 1922 Maryland Director 214-14-0652 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 XNo Parkville Director MD Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21234 U.S.A. 3119 Acton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2X Married XYes 2 No f Yes, Give White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Flementary/Secondary (0-12) College (1-4or 5+) Clerk Hardware store 6th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked ofth any july or other traumatic event, 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bigler Bowers Helen Hagelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Bowers/wife 3119 Acton Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NT Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) June 24, 2006 Baltimore, MD Gardens of Faith 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, MD Approximate Interval Between Onset and Death Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, o heart failure SC tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation M 2 Accident after death Director: 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMOZE MD 21274 MITEIN 4940

Registrar

State

31. Date filed (Month, Day, Yea

2

2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20063 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Linda Jane Crutchfield 2006 9:47 A^M June 24. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 Pecan Lane Essex <u>Baltimore</u> 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF AUG 9, 212-34-5254 Director 1936 69 Pennsylvania Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 2 Pecan Lane 21220 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiane. Spring Grove Elementary/Secondary (0-12) College (1-4or 5+) 12 Hospital <u>Cafeteria Supervisor</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other eny injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Edward Stewart ပို Sarah Eliza Bortell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Stewart/Brother 1945 Chipper Drive Edgewood, MD 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/26/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee reguil Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** DMARM resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 M No certificate 1 Yes funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No 26. Place of Death (Check only one) Hospitaf: 1 | Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3□ DOA 5 Pasidence 6 ☐ Other (Specify) 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. fnjury at Work? 28d. Describe how infury occurred Aftar 5 Pending investigation 1 Tes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. \$ignature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 26, 2006 of person who completed cause of death (Item 23a) (Type, Print) Kiumarce Kashi MD 3029 Dundalk Ave. Baltimore, MD 21222

DHMH 17 Rev 1/2001

State Registrar 31. Date fifed (Month, Day, Year) JUN 2 7 2006

			For State Registrar		aryland / D	epartment of H Certificate of L	ealth and l	Mental Hyg	iene g. No.	006	20064
*	Physici		Decedent's Name (First, Middle William	, Last) Anthony		Cernik		2. Date of Deat Month 06	Day	2006	3. Time of Death 5:00 p M
	/Medio Examin		4a. Fecility Name (If not institution Forest Hill H				Location of Death	h		nty of Death ford	•
	Funeral Director		5. Social Security Number 213-30-0767 Usual Residence of Decedent	6. Sex 7. Ag 1 1 M 2 □ F	ge (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/20/1	Year) 1934		place (State or Foreign ntry) Tyland
	farylend ed.at	or	10a. State 10b. County Maryland Harf	ford	10c. City, Town						10d. Inside City Limits
	or 28a-1	Director	10e. Street and Number			10f. Zip Code		1		of What Cou	•
	23a	in in	3833 Memory La			21009				d Stat	
36	n 72 hours after deeth with the Marylend "naturel", or Iteme 23a or 28a-f ehow salsal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' ed 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	o Rican, etc.)	E	Race - Americ Black, White, Incify: White	etc.
Maryland 21215-0036	n 72 hou n nature edical E	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a.	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of wor	rking	16b. Kind of	f Business/In	
1212	I be filed within nial Hygiene.		Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle,	College (1-4or	5+)	Conductor	18 Mother's Nar	me (First, Middle, M		1road	
auc	od o	Be		Cernik				arie Stok	-	/	
2	2 should be f and Mental b ie marked of raumatic eve	6	19a. Informant's Name/Relations		19b.	Mailing Address (Street a				wn. State. Zic	Code)
Z	s 1 end 2 should f Health and Mer Nem 27 le marke other traumatic		Mrs. Ginny L. (3833 Memory				on, MD	21009
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	cemeter	Disposition (Name of y, crematory or other place	e)	Date	20c. Locatio	on - City or To	own, State
Baltin	permit. Page Department of Important: If eny injury or once.		4 Donation 5 Other (S) 21. Signature of Funeral Service (May 7		Morela	nd Memorial 22. Name and Addres	s of Facility Mo	Comas Fu	meral	Home,	P.A.
			23a. Part1. Enter the disease a shock, or heart failure. List	complications that cause	d the death. Do r	1317 Coke	Sbury Ro	or respiratory arre	ngdon est	, MD	21009 Approximate
*	Physician /Medical Examiner)r	Immediate Cause (Final disease or condition resulting in death)	Due to (or as	s a consequence of	of):					Interval Between Onset and Death
68760,	cate be executed oblysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the original Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence o						
O. Box	The law requires that the death certificat site has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		of pregnancy 2 Fetal death at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)				Date of delive	ery Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant condition	ons contributing to death	but not resulting in	the underlying cause give	en in Part I.				he cause of death? pably 4 Unknown
Il Records,	The law requirete has been page 2 should	Completed						24a. Was a autops perform	ned?		opsy findings available impletion of cause of
Vital	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath Check only on			
Division of	ling Phys h. After this tuneral di	Certification: To	1 Yes No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investic 3 Suicide 6 Could	28a. Date of triggation	ay Year) li	ime of 28c. Injury World	y at (? Yes 2 □ No	28d. Describe ho	ow injury occ	curred	
Div	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide	building, e	tc. (Specify)		ne, data and plans	City or Town		That has be e	tatad
	• Hos 24 h • Fur letely	edical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination an	d/or investigation, in my o	pinion, death occu	urred at the time, di	ate and place	ce, and due to	o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifie	5		29c. License	2255	2	_	gned (Month,	
r	3+1		30. Name and address of person Dr. David Du			Type, Print)	1	Air MD	21014		2002
Sept.	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature		oo, ner	LILL 9 FID	21012	т	
DH	IMH 17 Rev 1/2		3011 2	2000	OR OR	GNAL					

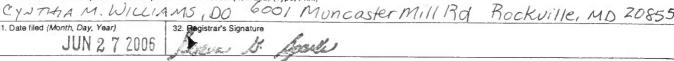
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20065 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2006 Michael L. Cleffi June 24, 11:38 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockv111e

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 7, Montgomery Hospice Casey House Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 152 M 2□ F 145-16-1569 83 Director New Jersey Usual Residence of Decedent •how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ∏Yes 2 No Maryland Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 11702 Seven Locks Road 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CIA Officer Federal Government Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other toury or other treumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael James Cleffi Theresa Malanga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia E. Cleffi/Wife 11702 Seven Locks Road, Potomac, Maryland 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 28, ortant: All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Germantown, Maryland Robert A. Pumphrey Funeral Home/Rockville, 21. Signature of Funeral Service Licenses Depar Impor eny In M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colorectal Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, cause of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physicien and the burial-transit Exam Due to (or as a consequence of) Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a o 9□ Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, cete has been significant control of the page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XJUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performe 2X No of Vital 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner ဥ 1 ☐ Yes 2 🛣 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospice 2 ER/Outpatient this 3□ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending efter death. 2 Accident investigation 1 Tes 2 No the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 24 hours Hospital 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause (s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29a Certifier Medical completely (Check only one) within 2 the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 Milliams DO H0058032 June 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 2006



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	Physici /Medic		Decedent's Name (First, Middle, Las ELLA	() 	М.	CC	HEN				JUNE 2		2006 ^Y °	ar	3. Time of Death 4:25 A м
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	Funeral Director		5. Social Security Number 6. Security Number 214-30-2649	x □ M 2	7. Age (In yrs. 93		If Under Months	Days	If Under Hours	Min.	8. Date of Bir Month D	"/ 1°9′	13	Birthpli Count	nce (State or Foreign Ty) MD
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<u>α</u>	tulres thet n signed b uld be deta	b	Part II. Other significant conditions of	ontributing to d	leath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t				cause of death?
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f Vital	nysiclan: T nis certificet director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆	Inpatient 2] ER/Outpatier	nt 3 DO	A Othe			n <i>(Ch</i> eck only o		6 □Other (S	Specify)	
Division of	the Hospital or Attending Physician: in 24 hours after deeth. the Funeral Director: After this certifica holetely filled in by the funeral director,		27. Manner of Death 1. Natural 5 Pending 2. Accident investigation		of Injury oth, Day Year)	28b. Time o Injury	f 21	8c. Injury Work 1 🗆 Y	at ? ∕es 2 □ l		28d. Describe	how inju	ury occurred		
Divis	ital or Att irs after de rel Direct led in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	288. Place build	e of Injury - At h ling, etc. (Speci	(fy)					City or To	wn, Stat	te)		Route Number,
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	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 7 200	6	Registrar's Sign	ature	who								

DHMH 17 Rev 1/2001

ORIGINAL

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		· ·	NORTHWEST HOSPITAL					.STOWN				TIMORE	
	Funeral Director		211 01 7010		yrs. last birtho 90 Yrs	Months	1 Year Days	If Under : Hours	Min.	8. Date of Birt 05/16	7916	9. Birth Cou	place (State or Foreign ntry) MD
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036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	in U.S.	I3. Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or No- tican, etc.)		Race - Ameri Black, White, ecify:	
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Baltimore,	Pages ment of I ant: if its jury or o		1 🗖 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	W	ORKMEN					/2006		DALK, M	
Ball	permit. Pag Department Important: i any injury o once.		21. Signatural Funeral Service License	Lev						LEVIN: OAD -			INC. MD 21208
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Δ.	ires that t signed by d be deta	þ	Part II. Other significant conditions conf	ributing to death but no	t resulting in th	e underlying o	ause givi	en in Part I.			obacco use		he cause of death?
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Re	The lav	ошо								autop	rmed?	prior to co death? 1 \(\sum \text{Yes}	mpletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	ne)	1 1 1 1 1 1 1 1	200 140
of V	Physician: this certific ral director,	일	1 ☐ Yes 2 No		2 ER/Outpa			4 🗆 Nu	rsing Hom	e 5 ☐ Resid	dence 6	Other (Special	(y)
o uc		lon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Tim Inju		8c. Injun Worl	/at k? Yes 2 □!		8d. Describe h	now injury o	curred	
Division	or Attenter deat	Certification;	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm	-		105 2		8f. Location (S City or Tox	Street and N vn, State)	umber or Run	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge, c	eath occurred	at the tin	ne, date an	d place, ar	nd due to the	cause(s) an	d manner as s	stated.
	he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medicel Examin one)	er: On the basis of examination and manner stated.	mination and/o	r investigation	, in my o	pinion, dea	th occurre	d at the time,	date and pla	ice, and due t	o the cause(s)
	with To t	Σ	29b. Signature and title of certifler	Pmch	1- no		. License	e number			29d. Date s	gned (Month	Day, Year)
	_		- Judice CC		ta m		NH	1141	0	-	JUNE	29	1 500 P.
	1.7		30. Name and address of person who con	HAR DIT M	(item 23a) (Ty	pe, Print)	061	HDE	1CY	MEH		211	33.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Resistrar's S	Gignature	1 1		JIME	- حا ۳ ا	IDENT	11/15	2 7!!	<i>.</i> .
	Regist	rar	JUN 2 7 20	UD Place	signature dis	goves							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM/18 per FH, G85/, 76/06 WS
State of Maryland / Department of Health and Mental Hygiene () () () 20068 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 23, 2006 4:30 A Ray Jui-Lin Chang /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Elkridge 8048 Hillrise Court 9. Birthplace (State or Foreign Country)
Taiwan 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12XM 2□ F Yrs 1977 28 Director 452-57-2506 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 17 Is marked other then "natural, or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Howard Elkridge MD 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number with 21075 USA 8048 Hillrise Court death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. o filed within 72 hours after it Hygiene. 1 □ Yes 2 If Yes, Give 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Chinese Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Accounting 12 4 Accountant 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H Be Feng Chin 2 Yuna-Nien Chana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8048 Hillrise Court; Elkridge, MD 21075 Yung-Nien Chang father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if ite eny injury or ot 2003. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) Hillton Service Corp. 7/1/06 Towson, MD 4 Donation 21. Signature of Fin ral Service License 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capse on a ch line. Approximate Interval Between fmmediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician /Medical Due to the as a continuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 ☐ Yes 2 1 Tyes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely (Check only one) and manner stated. the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier DO0 23887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleans spinder Richard

Registrar DHMH 17 Rev 1/2001

State

32. Agistrar's Signature

JUN 2 7 2006

31. Date filed (Month, Day, Year)

06-04461 Emma Davis

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 26, 2006 Year 0405 hrs Medical Examiner mma 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number) **Baltimore** N St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) < 2 X F 60 247-80-88 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10h County 1 X Yes 2 No 28a-f show altimor t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trment of Health and Mental Hygiene.
rrant: If item 27 is marked other than "natural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once, MI Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number West 1201 2+090 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 1 Never Married Married 2 X No Yes Specify: Black Yes 2 X No specify: Divorced Yes. Give Year 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 KEPPER 18.Mother's Name (First, Middle, Maiden Surname) (10) 17. Father's Name (First, Middle, Last) UNK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 S. Fremont Ave Apt. 418, Baltimore, MD 21201 Dameon Carter 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Department of Important: I 6/28/2006 Baltmore, MD 4 Donation 5 Other Specify 22. Name and Address of Facility
Youghn C Greene
5151 Batto Watt P 21. Signature of Funeral Service Licensee Funeral Paltimore, MD 21229 Pike reene 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Physician /Medical Cardiac arrythmia due to atherosclerotic cardiovascular disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical tending physician a use as the burial - 1 X UNPENDED AMENDED item#23a,PII,27,perME,g857,7/6/06 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Colon Carcinoma Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has perform<u>ed</u>? death? ✓ Yes 2 No page 1 🗸 Yes 2 No After this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient examiner? 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No ို 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending 24 hours after death To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe June 26, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. strar's Signature 31 Date filed (Month Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

acc G. Doody		1-For State Certificate of Degartment of He		, 0	eg. No. 200	6 200
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Grace G. Doody		2. Date of Deat Month June 26, 2	th Day Year	3. Time of Death 0055 hrs
3		6: -11 -: 1	ity, Town, or Location of De		4c. County of Death	1
Funeral Director		219-12-6807 _{1 M 2} X _F 83 _{Yrs.}	Under 1 Year If Under 24H Ionths Days Hours M	4:	th(MM/DD/YYYY) 9. Bir 3, 1922 Foreig	
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a State	ore Zip Code	10	Og Citizen of What Coul	10d. Inside City Limit 1 Yes 2 X N
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	Funeral Dire	1 Never Married 2 Married Armed Forces? If Yes, s	21244 cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	USA - 14. Race - Amer White, etc.	can Indian, Black,
72 hours after d "natural", or il Examiner m	by	3X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Ut	2 X No specify: sual Occupation (Give kind of f working life. DO NOT use r	of work done retired)	Specify: Whi	
21215-0036 Id be filed within 72 Aental Hygiene. narked other than event, the Medical	e Completed	12 Adminis 17. Father's Name (First, Middle, Last) William Oden Phillips		stant me (First, Middle, M ce Seller:		!
MD 212 td 2 should be alth and Menta m 27 is marka aumatic even	To Be	19a Informant's Name/Relationship (Type, Print) Mr. Carroll Phillips (Brother) 7705 Pa.	rk Heights Av	or Rural Route Num	nber, City or Town, State sville, MD	21208-4320
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b Place of Disposition crematory or other pl Mt. Olive Co	emetery 6/	²⁹ /2006	20c. Location - City or Randallsto	wn, MD
Physician /Medical		21. Signature of Funeral Service Licensee OLUMA. Adulg the MOONGY Syke: 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mofailure. List only one cause on each line.		ME & CHAL 784 (410 c or respiratory arre	PEL, PA (Bo)-795-1400 est, shock, or heart	Between Onset an
Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Fining the deriving Cause. Leg injuries with complication to (or as a consequence of): Due to (or as a consequence of):	LIGIS			Death
executed tan and al - transit	cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED AMENDED AMENDED AMENDED AMENDED	nME.g857.7/15/00	5 TT		
ox 68760, eath certificate be attending physicifor use as the buri	hysician/Medical	1	_	gnancy	23d. Date of delivery Month D	day Year
ords, P.O. B in requires that the d as been signed by the should be detached	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	1 Yes 24a. Was a autops	an 24b. Were au	
tal Reco ian: The law certificate has ector, page 2 sl	Be Com	25 Was case referred to medical examiner?	26.Place of Death (Chec	perform 1 Yes 2 ck only one)		s 2 No
Division of Vital Records, tal or Attending Physician: The law requir safer cleath as after cleath all Director: After this certificate has been seled in by the funeral director, page 2 should I	ျ	examiner? 1 Very Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 XX Accident Investigation 10:08 am		28d. Describe h	Residence 6 Other ow mjury occurred as driver in a	
Division dospital or Attend hours after death uneral Director:	Il Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify) roadway		Road Balt	treet and Number or Rui ate) 5500 block timore, MD	of Keisterst
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred a more of the basis of examination and/or investigation, is and manner stated. 29b. Signature and the of certifier				e cause(s)
			reet, Baltimore, MD 2	21201	- Julie 20, 2000	
Regis	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature				
IVH III Rov ha	UUT	ORIGINAL				

OCME 2006

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 22, WILLIAM MARTIN 11:15 a^M DORSEY June 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12302 Silverbirch Lane Laurel Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1∏ M 2□ F Months Yrs. Director 234-20-5896 83 May 7, 1923 West Virginia Usual Residence of Decedent the Maryland la or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX Maryland Prince George's Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With ai', or items 23a Examiner must 12302 Silverbirch Lane 20708 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1XXYes 2 ☐ No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes ZXNo Specify: Specify: White þ WWIT 3 Widowed 4 Divorced Year or Dates: natural', or than "natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Fire Department Grade 12 Firefighter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin William Dorsey Fonda Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 spouse Cora Wilma Dorsey 12302 Silverbirch Lane Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 Burial 2XX cremation 3 Removal from State West Arundel Crematory 6/24/06 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. - / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebral Thrombosis with Infarction years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Monoclonal Gammopathy 1 ☐ Yes 2 XXio 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2000No certificate 1 ☐ Yes 2XXNo 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2XXNo Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1XXIatural 5 Pending death. Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after des To the Funeral Director completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ditier 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) D 54853 June 22, 2006 UM 18×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane Danny Lee, M.D. Laurel, Maryland 31. Date filed (Month, Day, Year) JUN 2 7 2006 32. Registrar's Signature State DEALE) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4onth SERALDINE /Medical Facility Name (If not institution, give street and m, or Location of Doath Abocity, To 4c. County of Death Examiner NI 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 8 Date of Birth (Month, Day, **Funeral** Days Hours 1 ☐ M 2 💢 F -22-Yrs. Director TULY08.191 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ØYes 2 □ No MARVLAND

10e. Street and Number BALTIMORE 101. Zip Code Director 10g. Citizen of What Country? f Health and Mental Hygiene. Item 27 ia marked other than "natural", or Items 23a or i other traumatic avent, it a Medical Examinar musi he n 120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+HGRADE LEVINDALE MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOUIRREL ၉ TON MARV VICTORIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, Slate, Zip Code) (DAUGHTER JOYCE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o Burial 2 Cremation 3 Removal from State NATIONAL (EME 06-30-06 4 ☐ Donation 5 ☐ Other (Specify) LAUREL 21. Signature of Funeral Service Licensee ROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory afrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 5 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? contribuţing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo ို Diractor: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours el To the Funeral D completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and Jenel 31. Date filed (Month, Day, Year) State JUN 2 7 2006 Registrar

DHMH 17 Rev 1/2001

P.M.

DALY, MARGARET

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Depa	artmen		Ith and I	Mental Hyg	iene eg. No.	2000	20 (0.7
Physicia /Medic Examin	al	Howard Charle 4a. Facility Name (If not institution, gives 7078 Saddle Drive	s Erbe		4.	Town, or Loca		June 2	23 Day	Year 2006 County of Death	9:15p	M
Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under Months	r 1 Year If L	Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day May 26		9 Birth	pplace (State or F untry)	Foreign
he Maryland 8a-f ehow	ector	Md 10b. County Carroll		ty, Town or Lo)						10d. Inside City	
th with to	ai Dir	10e. Street and Number 7078 Saddle Dri	ve		10f. Zip	21784		1		en of What Cou JSA	intry?	
urs after deal	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If #es, Give Year or Dates:	r-	Was Decedif Yes, spe		ic Origin? (Specifican, Puerto ecify:	pecify Yes or No- Rican, etc.)		Race - Amer Black, White Specify: White	, etc.	
d within 72 hours after death with the Maryland siene. Then then naturel, or items 23e or 28e-f ehow the Madical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of wo DO NOT u	al Occupation ork done during se retired)		king	16b. Kind	d of Business/li	ndustry	
ges 1 end 2 should be filed within 72 hours aft in of Health and Mental Hygiene. If filem 27 is marked other then "naturel", or or other treumetic event, the Madical Exami	To Be Co	17. Father's Name (First, Middle, Last) Howard Erbe				18.	Mother's Nam	e (First, Middle, I Johnson	Maiden S	umame)		
		19a. Informant's Name/Relationship (Ty. Mildred B. Erbe (s			_			ville, M			p Code)	
permit. Pages 1 er Department of Hea Importent: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	attionatitioni State 1		y Cre	emation		-06	Syke	ation - City or T	Md	
permit. Depart Import any inj		21. Signature of Funeral Service License Para Saught	Sperbers	22 F	2. Name ar 2. O. H	nd Address of Box 195	^{Facility} Hai Svkes	ght Fune ville, M	ral d 21	Home & 784	Chape1	
that the death certificate be executed which is the attending physicien and detached for use as the burial-transit detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	quence of): quence of):	ter	al S Arre	sele-	0313	AL	s)	Interval Betwe Onset and Dei	ath
hat the death certifica dby the attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3[Ectopic pr				23	d. Date of delive	ery Day Yea	ar
The law requires that the steep seem signed by the page 2 should be detached.	Ď	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying c	ause given in	Part I.		acco use		the cause of deal	
	Completed	05 Wo							ned?	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings ava empletion of cause 2 No	ailable se of
Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DC	100		h <i>Check only on</i> ome 5 2 Reside		□Other (Speci	fv)	_
To the Hospital or Attending Physician: within 24 hours elter death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	8c. Injury at Work? 1 \(Yes		28d. Describe ho	w injury	occurred		
Hospital or Al 24 hours efter of Funeral Directely filled in by		4 Homicide determined 29a. Certifier 1 Certifying Physics	28e. Place of Injury - At h building, etc. (Special sician: To the best of my known in the second second second second second second second second second second second second second second second second second second sec	owledge, death	h occurred	at the time, da	ite and place.	28f. Location (St. City or Town	, State)	nd manner as s	stated	r,
the Ho hin 24 h the Fu	Medicai	one) 2 Medical Examil	ner: On the basis of examina and manner stated.	ation and/or in	vestigation	, in my opinion	, death occur	red at the time, de	ate and p	lace, and due t	o the cause(s)	
T vilt		29b. Signature and title of certifier			1	DOOS		1		signed (Month,		
6		Braeme Glaus	mpleted cause of death (Iter	n 23a) (Type,	Bel	veder	e Ave	1 2. Bal	to.	UD Z	21215	
Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 2	32. Registrar's Signa	ature .	book							

		1	State of Maryland / Departm State Amend Item #5 Per FH 8857 6/03/06 Registrar	nent of Health and Me Cate of Death	ntal Hygiene	2006 20075
	Dhysisis		Decedent's Name (First, Middle, Last)	2	2. Date of Death Month Da	3. Time of Death
	Physicia /Medic	al -	Hazel M. English	City, Town, or Location of Death	June 21	2006 4:05 p M
* K.	Examin	er '		arkville		Baltimore
	Funeral Director		215~ 66 ~5903 1□M 2ØF 73 Yrs. Mo	onths Days Hours Min.	Date of Birth (Month, Day, Year Dec. 19,	9. Birthplace (State or Foreign Country) 1932 Pennsylvania
	land ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits
	Mary B-1 eh	tor	Md. Baltimore Parkville			1 □ Yes 2 No
	or 28	Director	Too. Grost and Manager	Of. Zip Code	10g. C	itizen of What Country?
	eath w	erai	2702 E. Joppa Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21 234 Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto Ri	rfy Yes or No-	14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other traumatic event, the Madical Examinating the notified at ODEs.	by Fur	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	s, specify Cuban, Mexican, Puerto Ri Yes 2. No <i>Specity:</i>	ican, etc.)	Black, White, etc. Specify: White
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and 2	d be filed ental Hygie ced other cevent, II	To Be Co	17. Father's Name (First, Middle, Last) Charles N. Shaffer	18. Mother's Name (Blanche		n Surname)
Maryland	Ith and M 27 Is mar			ddress (Street and Number or Rural Joppa Rd. Park		
Baltimore,	Pages 1 arent of Heanut: If Item	-	20a. Method of Disposition 1 ⋈ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, cremato Dulaney Val	ry or other place)		Location - City or Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licenteee 22. Na Ruc	nme and Address of Facility ck Towson Funeral 50 York Rd. Towso	Home, In n, Md. 21	204
¥.,	THE STATE		23a. Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heer failure. List only one cause on each line.			Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence of):			
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O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Med		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
۵.	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds,	ed sign		EMPHYSEMA		1 🗆 Yes	2 No 3 Probably 4 Unknown
Record	The law requires that the ate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital		Be C	25. Was case referred to medical examiner?	26. Place of Death		
f	shys this aldi	2	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		ne 50 Residence 8d. Describe how in	6 ☐Other (Specify)
	Jing After fune	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		
Division	after death after death Director: A	Certification;	3 ☐ Sutcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or A within 24 hours after To the Funeral Direction places on the Completely filled in by	Medical C	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examination and/or invessed and manner stated.	courred at the time, date and place, a tigation, in my opinion, death occurre	nd due to the cause od at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature of title of certifier	29c. License number D57313	J	Date signed (Month, Day, Year) NE 27, Zeo6
1	T		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince CHANES WEEE, MD Z30)	o w Jopp +	+ 120	LUTH ORVILLE MY 21093
	St Regis	ate trar	31. Date filed (Month, Day, Year) JUN 2 7 2006 32 Registrar's Signature	à		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day JUNE MARY TERESA **ECKENRODE** 21, 1:20 P. M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 210 LINDEN AVENUE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-19-1910 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M XXXF 215-24-4046 96 MASSACHUSETTS Vrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at MD. TOWSON BALTIMORE 1 Yes 2XXNo Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 210 LINDEN **AVENUE** 21286 U. S. A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2XXNo þ XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Callege (1-4or 5+) YEARS HEALTH CARE REGISTERED NURSE permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: If Itam 27 is marked other th eny injury or other treumatic event, the page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be STEPHEN AVERY ALICE DANFORTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. ECKENRODE (DAUGHTER) 210 LINDEN AVENUE, TOWSON, MARYLAND, 21286 MILLIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Deurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 06-24-2006 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R. G.RUTH) Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 💥 No 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed? Yes XXNo certificate Atter this certification funeral director, a To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes XX No Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3 0 JUNE 22, 2006 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 5. 7 MD Kobert 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 27 2006 Registrar

			For State Registrar	State	of Maryland /	Department of Hea Certificate of De			~ U U U	20077
ľ			1. Decedent's Name (First, Midd	1	10.0			2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic	al	000	ne	Fenn			June 2	3,2006	12,32 PM
,	Examin	er	4a. Facility Name (If not institution	n, give street and no	Cente	4b. City, Town, or Lo	Sign of Death	44	c. County of Deat $Ba I$	times o
	Funeral		5. Social Security Number	6. Sex 1 M 2 □ F	7. Age (In yrs. last b	Months Days F	Hours Min.	8. Date of Birth (Month, Day, Year) Co	hplace (Stete or Foreign
	Director		067-58-8720 Usual Residence of Decedent	18	1 30	Yrs.		march 21,	1970 Ne	w york
	aryland show	_	10a. State 10b. Count	2-11-	10c. City, To	wn or Location .	11.			10d. Inside City Limits
	the Mi	Director	10e. Street and Number	accus	2	/ 10f. Zip Code	110	10g, C	itizen of What Co	
	deeth with the Maryland ma 23a or 28a-f ehow must be myllillad at		5915 L	aclea	de Ko		12-06		U5	A
		Funeral	11. Marital Status 1 Never Married 2 ■ Ma	Armed F	cedent Ever in U.S. Forces? 2 19 No	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Spec Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
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2-0	"natu	Completed	(Specify only high	nt's Education est grade completed	16	Decedent's Usual Occupatio (Give kind of work done durin life, DO NOT use retired)	n ng most of workin	g 16b. I	Kind of Business/	Industry
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Maryland	d 2 should h and Men 7 le marke traumatic	ဥ	19a. Informant's Name/Relation	ship (Type, Print)	19	b. Mailing Address (Street and				
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altimore,	Pages 1 e nent of Hee int: If Item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		n State cemet	of Disposition (Name of ery, crematory or other place)	1/1	20c. l	ocation - City or	1
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				r complications that t only one cause on	0.20	not enter the mode of dying, s	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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Box		ın/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnancy	th 3□Ectopic pregnancy			23d. Date of del	ivery
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ords	v requires been sign should be							1 Tes 2	2 No 3 □ Pr	obably 4 Unknown
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only 2 Medical one)	I Examiner: On the	basis of examination a baner stated.	ge, death occurred at the time. and/or investigation, in my opini	date and place, ar ion, death occurred	nd due to the cause(: d at the time, date ar	s) and manner as nd place, and due	to the cause(s)
	Vithir To th	ž	29b. Signature and title of certific	er I		29c. License nu	umber	29d. D	ate signed (Monti	Day, Year)
}	١.		30 Name of address of person	who completed as	USA Of death (from 33)	1 D 78.	J 4 5	70	News	
_	Ų		30. Name and address of perso	Arues M	0 6601 1	2 Cliarles St	BAUTH	ies up	croy	
	Sta Regist		31. Date filed (Month, ban Ye	7 2006 32.	Registrar's Signature	Sparke				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2006 Month **Physician** June 20 Robert Henry Fish 8:12 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 🗷 M 2 🗆 F 77 Maryland 219-22-9387 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow 1 Yes 2 No Directo Baltimore City Md. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 N. Calvert Street 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 🎽 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then College (1-4or 5+) Elementary/Secondary (0-12) Health Care Administrator Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if them 27 is marked oth any liqury or other traumatic event page. Earl Η. Fish Thelma Ostendorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Rhonda L. Fish/Daughter 18 Estates Ct. Unit#6208 Baltimore, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/06 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, I any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes SENO 2 ER/Outpatient 3 DOA To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Natural 20 Accident Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Medical Exeminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 21204 N. Charles St. 32 Registrar's Sign State Registrar

		1	For State Registrar	State of Maryl		artment of H rtificate of L			Reg. No.	06 20079
4 3	Physicia /Medic	in al		FEN WIC	CK	4b. City, Town, or	Location of D	2. Date of De	Ho County	<u> </u>
	Examin	9	la. Facility Name (If not institution, gin	2 NOSPITA	yrs. last birthday,	BALTIN	If Under 24	modiffy	^	9. Birthplace (State or Foreign
	Funeral Director			Sex 7. Age (In	42 Yrs.	Months Days		Hrs. 8. Date of Bir	1963	Maryland
	Maryland	,	10a. State 10b. County	1/A	c. City, Town or L	Baltim	ore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28a	i Direc	10e. Street and Number	olHon Ave	•	10f. Zip Code	21223	3	10g. Citizen of W	hat Country?
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Haalth and Mental Hyglene. ortant: If item 27 le marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, ite Medical Exornine must be notified at injury or other traumatic event, ite Medical Exornine must be notified at .	by Fur	11. Marital Status 1	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	jn U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		? (Specify Yes or No uerto Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. Black
21215-0036	within 72 horiene.	Completed	15. Decedent's E(Specify only highest g	Education rade completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	durina most of	working	16b. Kind ol Bu	siness/Industry
	ould be filed Mental Hygin arked other atto event, I	To Be C	17. Father's Name (First, Middle, Las Frederick				18. Mother's Mar	Hame (First, Middle Gro	, Maiden Sumam 2/U	a)
Maryland	nd 2 shoul alth and Me 27 le mari ir traumati		10- Informant's Name/Polationship		19b. Mai	ling Address (Street	and Number of		Ballino	State, Zip Code) 21223 e Maryland
Baltimore,	Pages 1 and not of Hazant: If item		20a. Method of Disposition 1	☐Removal from State	Ob. Place of Disp cemetery, cri	ematory or other place	ry	7/3/06	Land 5d	owne Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of ineral Service Lic. 23a. Part1. Enter the disease, or co	ife	3	572 Fred	lenck	Are. B	affinere	Maryland 9
8760,	Physician /Medical Examiner physician and physician and the priviler and t	dical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPS Due to (or as a co	onsequence of): I F M L onsequence of): D M M	PNEC C AB	NMO. USE	N/A		Onset and Death
O. Box 68	it the death certificat by the attending phy tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	I □Ectopic pregnanc □ Other (specify) _	у		23d. Dat Mor	e ol delivery nth Day Year
Js, P.O.	ires that It signed by d be detac	by Ph	Part II. Other significant conditions END STAGE		ot resulting in the		ven in Part I.		tobacco use conti	ribute to the cause of death? 3 Probably 4 DUnknown
Recor	he law requir ie has been si age 2 should	Completed	HY REN JEN SEIZUNES	1510 N				24a. Wa aut per 1 \(\triangle Yes	formed?	Were autopsy lindings available orior to completion of cause of death? ☐ Yes 2☐ No
Vital	ysician: The l is certificate his director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpati	ient 3 DOA Ct	han	f Death (Check only		er (Specify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Certification; To	27. Manner ol Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injury	of 28c. Inju	ıryat ork?]Yes 2∐No	28d. Describe	how injury occurr	
_	Hospita 24 hours Funeral stely filled	Medical C	29a. Certifier (Check only 2 Medical Ex	Physician: To the best of maniner: On the basis of examiner: On the basis of examiner stated	amination and/or	ath occurred at the tinvestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	e cause(s) and ma e, date and place,	anner as stated. and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	nopheels.	m.D.	014	se number		6/26/	d (Month, Day, Year)
	le		30. Name and address of person w	ho completed cause of deat	h (Item 23a) (Typ	De, Print) 7007 SAV	1/40 M	MI MUN	E STRE	ee 7 3
¥	Si Regis	ate trar	31. Date liled (Month, Day, Year) JUN 2 7	32. Registrar's		Coarles				

			1 - For State Registrar	tate of Maryla	-	artment of F rtificate of			jiene 200	6 20080
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Marjorie		Fuller			2. Date of Dea June 2	th 25 ^{Day} 2006 ^{Year}	3. Time of Death 3:25 P M
	Examir		4a. Facility Name (If not institution, give stree Pickersgill			Towson	r Location of Deat		4c. County of Dea	
	Funeral Director		5. Social Security Number 216-47-3412 6. Sex 1 M		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	1, 1923 9. Bi	rthplace (State or Foreign Chitma
	Maryland	tor	10a. State Md. Baltimore	10c. C	City, Town or Lo TOWSON	cation				10d. Inside City Limits 1 Tyes 2 No
	th with the 23e or 28.	al Director	10e. Street and Number 615 Chestnut Ave.			10f. Zip Code 2120	4	1	0g. Citizen of What C USA	•
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Marcial Examination untilled at Once.	by Funeral	1 X Never Married 2 Married	Vas Decedent Ever in Armed Forces? □Yes 2ऄ॔No fYes, Give Year or Dates:	1	Vas Decedent of F f Yes, specify Cub I ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	d within 72 ho giene. In then "natur	Completed	15. Decedent's Educatic (Specify only highest grade co.	on mpleted) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done 20 NOT use retired NOWN	eation during most of world)	rking	16b. Kind of Business Unknown	s/Industry
yland	iould be file I Mental Hyg narked othe netic event,	To Be C		ıller			Seraph		Laskovsi	
e, Mar	1 and 2 sh Health and em 27 Is m ther treum		19a. Informant's Name/Relationship (Type, in Mr. Harry McKillop/ F	riend	19b. Mailin 2300 Place of Dispos	West Pl	and Number or Ru ano Pkwy	PO Box 2	, City or Town, State, 269014 Pla	no, Tx. 75026
Itimor	iit. Pages Intment of I Intent: If its Injury or o		1 ★ Burial 2 □ Cremation 3 □ Remo 1 ★ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	wal from State	cometery, crem can Gro	ve Cemet	ery 6-30	-06	McKinney,	
Ba	Department of the partment of	0 /	23a. Part1. Enter the disease, or complication	his that caused the de		1050	fork Ra	• Towson	Home, Inc., Md. 2120	4 Approximate
8760,	cate be executed why sician and physician and the burial-transit	dlcal Examiner	shock, or heart failure. List only one be Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying cause (Lisease or in jury that initiated events resulting in death) Last d	Due to (or as a conse	equence of):	neum	mia			Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	f yes, outcome of pregr □Live birth 2□Fel □Pregnant at time of □Unknown	tel death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contribu		sulting in the un		en in Part I.	23e. Did tob	acco use contribute to s 2 ☑ No 3 ☐ P	o the cause of death? robably 4 DUnknown
Vital Records,		Completed	os Warner at a la la la la la la la la la la la la l						prior to death?	utopsy findings available completion of cause of s 2 \square No
Division of Vit	ding Phys .r After this funeral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	tal: 1	28b. Time of Injury	28c. Injun Wor	er: 4 Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe	rcity)
Divis	Hospitel or Attend 24 hours after death Funerel Director: tely filled in by the	Certification:	4 Homicide	Be. Place of Injury - At I building, etc. (Spec	ify)			City or Town		
	To the Hospitel or within 24 hours after To the Funerel Dirticompletely filled in I	ledical		n: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or inv	estigation, in my o	pinion, death occu	rred at the time, da	te and place, and due	e to the cause(s)
	To with	Σ	29b. Signature and title of certifier	2 Rely	, mo	DD 3	~11-	_	Id. Date signed (Mont	
	ĵO		30. Name and address of person who comple of the field (Month Jan Marry 2006)	eted cause of death (Ite	m 23a) (Type, F N - Cha	les St.	Balto.	md 210	204	
	Sta Registr	te ar	31. Date filed (Month Day Ygar 7 2006	32. Hegistrar's Sign	nature, Age	ele				

06-04171

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Christopher Foster 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ Month Day June 16, 2006 1220 hrs **Medical Examiner** CHRISTOPHER FOSTER 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital n/a If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ForeignSOUTH Months Days Hours MAY 14,1962 Director 249 37 6424 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 1 XYes 2 No N/A BALTIMORE items 23a or 28a-f show MD. notified at once. with the Maryland Director 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country 21213 3532 LYNDALE AVENUE USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married hours after death Yes 5 Yes 2 X No specify: Yes, Give Yea Specify: BLACK the Medical Examiner Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 marked other than MD 21215-0036 LABORER STEEL AND WIRE PROD. 12 tment of Health and Mental Hygiene.

rant: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEX FOSTER MARY DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARETHA FOSTER (sister) KENYON AVE. BALTO, MD. 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition timore. crematory or other place) Burial 2 Cremation 3 Removal from State ULY 1,2006 BAPT.CH BLACKSTOCK, S.C. REDHILL CEM. Donation 5 Other Specify permit. Departn ature of Funeral Service License SCRUGGS FUNERAL HOME proximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, **Physician** failure. List only one cause on each line. Medical Death a. Smoke inhalation Immediate Cause (Final disease [⊤]xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -AMENDED UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknow the 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an certificate has been a 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: Hospital: 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month, Day,Year) Unknown 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Victim of a garage fire 1 Natural Unknown Yes 2 V No Pending filled in by the f 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) 1206 North Dallas Street, Baltimore, MD Suicide (Specify) In a garage Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 17, 2006 pm9 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 32. Registrar's Signatu State 2008

Registra

			For State Registrar	State o	f Marylan		artment of H		Mental Hygie	ene 2006	5 20082
			Decedent's Name (First, Middle, La	est)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Vera D.	Grof					June 26	Day 2006	18:30 M
	Examin		4a. Facility Name (If not institution, gir	re street and nu	mber)		4b. City, Town, o	or Location of Death	1	4c. County of Deat	h
			Carroll Hospit	al Cent	er			ninster		Carro	
	Funeral			Sex 1□M 2□F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign untry)
	Director			1□M 2□F	90	Yrs.			July 9,	1915 Yug	goslavia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Aaryl f sho	ŏ	MD Carro	.11			Sykesy	r i 110			1 ☐ Yes 2 ☐ No
	the 28s-	Directo	10e. Street and Number				10f. Zip Code	11116	100	. Citizen of What Co	untry?
	3a or		5801 Dale Drive					21784		USA	
	death ma 2:	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.		Hispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
٥	or he		1 ☐ Never Married 2 ☐ Married	Armed For 1 Yes If Yes, Gir Year or I	2V No				o Hican, etc.)	Black, White	
215-0036	s filed within 72 hours after death with the Maryland Llygiene. other then "naturel", or Itema 23e or 28e-f show ont, ite Madical Examinar must be notified at	1 by	3 ☐ Widowed 4 🖾 Divorced	Year or D	ates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: W	/hite
2	72 h	Completed	15. Decedent's E (Specify only highest gi			16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of world)	king 16	b. Kind of Business/	Industry
2	Athin nen nen	m	Elementary/Secondary (0-12)	College (1-4or 5+)			a) erior Des:		omogtic/Tr	iterior Desig
2	filed w Hygie other ti		17. Father's Name (First, Middle, Las	+1	2	Tiomem	IRCI / LIICE		ne (First, Middle, Ma		iterior besig
Ĕ	\$ 5 5 5°	Be	Stephan Dinj						va Ilich	addit gamamo,	
Ž	should be and Menta marked umatic ev	ဠ	19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·		19b. Maili	na Address (Street	·		City or Town, State, 2	(ip Code)
Maryland 21	2 2 2		Ms. Virginia Scha		Daughte		-				
	Health tem 27 other tr		20a. Method of Disposition				sition (Name of matory or other pla			c. Location - City or	
altimore,	00		1 ☑ Burial 2 ☐ Cremation 3 i 4 ☐ Donation 5 ☐ Other (Spec		State		w Mem. Pa	- 1a 1a	2006 S	kesville,	MD
量	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service Lice								
ñ	P G F G		Blian & Al	right	400	769 11	Sykesvill	e. MD 21	784 (410)-	L, PA (Box -795-1400	193)
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that	caused the deat						Approximate Interval Between
V.	Physician		Immediate Cause (Final disease or condition	C	Pitie so	Mar	to Chetic	liver diff	cile		Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consec	uence of):	ic Civijiia	river activiti			~ C
	Examiner		Sequentially list conditions	b							
	0 1/=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence of):					
	and and trans	Examiner	that initiated events resulting in death) Last	C	(or as a consec						
8760,	ibe executed sicien and contract			500 10	(or as a consec	(derice of).					
	ate he	dical		d							
9 X	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn	ancy				23d. Date of deli	verv
Box	eath atter	ciar	in the past 12 months?	4□Preg	birth 2 ☐ Feta nant at time of c]Ect <i>o</i> pic pregnanc] Other (specify) _	y		Month	Day Year
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ď.	The law requires that the ste has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions	contributing to d	leath but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	v require been sig should b		Clerence Hyric	1 hope	Mateur				1 ☐ Yes	2 🖪 No 3 🗆 Pro	obably 4 Unknown
ပ္က	ne law requ has been ge 2 shoult	Completed							24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Œ		μοχ							performe	d? death?	2 → No
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one)		
Ž	Ø ₹	2	1 ☐ Yes 2 ☑ No] ER/Outpatie	IL SEL DOA			ce 6 □Other (Spec	oily)
בַ	ding Ph J. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time o Injury	Wo		28d. Describe how	injury occurred	
<u>s</u>	death. ctor: A	cati	2 Accident investigati 3 Suicide 6 Could not	he -				Yes 2 □No	004 L (Chan	-1	
Division of Vital Records,	l or Atten after deat Director: I in by the	Certification:	4 Homicide determine	289. Plac	e of Injury - At n ling, etc. <i>(Speci</i>	ome, tarm, st fy)	reet, factory, office		City or Town,	et and Number or Ru State)	rai Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Cartifying F	hysician: To th	e hest of my kn	owledge dos	h occurred at the fi	me date and place	and due to the cou	se(s) and manner as	stated
	To the Hospital within 24 hours and To the Funaral completely filled	edicai	(Check only 2 Medical Ext	iminer: On the t	pasis of examination stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Licen	se number	290	I. Date signed (Monti	n, Day, Year)
	r s F ö		1 laterely 7	·			100	0806		6/27/06	
,	1		30. Name and address of person wh	completed cau	se of death (Ite	m 23a) (Type.	Print)	1		1.0	
	6		HATRICK TUR	Wes on)	1000	IBURTY K	D Ed	erred at the time, date 290	UD 2/78	ry
	Sta	ite	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign	ature	1 .				
1	Regist	ar	30N 2 7	ZUUD	Cherry	15.	grave .				

			For State	State	of Maryla		artment <i>rtificate</i>		ealth and N Death		_	4000	20083
	_		Registrar 1. Decedent's Name (First, Middle, L.	ast)			imodio	0, 2		2. Date of De	Reg. N	10.	3. Time of Death
	Physicia	an	Letha	Marie			Gray			Month June		ay Year	11:25A ^M
	/Medic Examin		4a. Facility Name (If not institution, gr		ımber)			own, or	Location of Death	June		Ic. County of Deat	
	Examili	CI	509 Darlene Ave				Lir	nthi	CIIM			Anne Aru	nde1
	Funeral			Sex	7. Age (In yı	s. last birthday)	If Under 1	Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birtl	nplace (State or Foreign untry)
	Director		116-26-8315	1 □ M 2 🕅 F		78 Yrs.	Months	Days	Hours Min.	(Month, Da	,19	27	NY
	p		Usual Residence of Decedent		100	Cit. Town and							10d. Inside City Limits
	eryta ehov	_	10a. State 10b. County	1 1		City, Town or Lo							1 ☐ Yes 2 No
	8a-f	ectc	MD Anne An	runaeı	L	inthicu	-	2- 4-			10- 0	Citizen of What Co	
	with t	ă	10e. Street and Number				10f. Zip (untry?
	e 23	Funeral Director	509 Darlene Aver		edent Ever in	IIS 13 V	210		spanic Origin? (Sp	ecify Yes or No		U.S.A. 14. Race - Ame	ncan Indian
_	ter d	Ë	1 Never Married 2 Married	Armed F	orces?				spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	•	Black, White	e, etc.
2	urs a	þ	3X Widowed 4 □ Divorced	If Yes, G Year or I	ive Dates:		1 🗌 Yes 2	□XNo	Specify:			Specify: Wh:	ite
5	2 ho	Completed	15. Decedent's i	Education	1	16a. Deced	dent's Usual	Occupa	tion uring most of work	ring	16b.	Kind of Business/	Industry
Ž	thin 7	pie	Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	DO NOT use	retired))	arig			
V	ad wi	Con		4	+	Occup	ationa		ealth Nu				Company
2	be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural; or itame 23s or 28s-f show event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Las	st)					18. Mother's Nam	e (First, Middle	, Maid	en Sumame)	
2	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itame 23s or 28s-f show sumatic event, the Madical Examinar must be notified at	ဥ	Harry S. Dyer					(2)	Myra V.		0.	or Town, State, 2	
20	12 st h and 7 te m traum		19a. Informant's Name/Relationship Mr. Zachary S.		Son	1	• ,					rida 337	
ָ ט	1 and Healt em 2		20a. Method of Disposition	oray / c		Place of Dispo						Location - City or	
	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	_{сетекегу, сгег} hesapea				-	S	tevensvi	11a MD
Банттог	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 te marked any injury or other traumatic es	. 4	21. Signature of Squared 33 vice Lice				Ne Gre 2. Name and		1011				ome, P.A.
מ	Depa Impo any ir		- Lelde	- M	SH de	1	Secon	nd A				ie, MD 21	
n			28a. Part1. Enter the disease, or co	mplications that	caused the de								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	M	0+257	Latic	Can	0.0	~ /1/2	1	00	Dr. mary	Onset and Death
	/Medical		resulting in death)	Due to	(or as a cons	equence of):	αn	CTI	~ / Un	ICHO CU		11,110,7	month
	Examiner		Sequentially list conditions,	b	-,								
V	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a cons	equence of):							
-	death certificate be executed to attending physician and ad for use as the burial-transit	xan	that initiated events resulting in death) Last	c	(or as a cons	equence of):							
00/	be e sician buria	dical E											
200	ficate p physics ts the	edic		d									
×	nding use a	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome of preg						N	23d. Date of deli	very
ă	uires that the death certific signed by the attending f d be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Preg	birth 2 □Fe gnant at time o		Ectopic pre Other <i>(spe</i>					Month	Day Year
5	requires that the	hys	9 🗆 Unknown	9□ Unki	nown					1			
Š.	es the	by F	Part II. Other significant conditions	contributing to	death but not r	esulting in the u	ndertying ca	use give	n in Part I.				the cause of death?
coras,	w require been signated should b	te d			-					10	Yes	2ØNo 3□Pro	obably 4 Unknown
ပ္	law ras be	Completed								24a. Was	psy	24b. Were au	topsy findings available completion of cause of
<u> </u>	sician: The law certificate has b lirector, page 2 s.	ပ္ပ								perto 1 ☐ Yes	ormed? 2 € 1		2 🗆 No
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital				000	26. Place of Deat	h (Check only	one)		
	Physic this caldir	7	1 Yes 2 No	-		ER/Outpatier			4 Nursing Ho	ome 5 Res		6 ☐Other (Spec	cify)
DIVISION OF	iding Physician: th. After this certifical tuneral director, p	io	1 ☑Natural 5 ☐ Pending		of Injury nth, Day Year,	Injury	M	c. Injury Work	es 2 □ No	Zdd. Describe	IIOW III	jury occurred	
2	deatl deatl ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not	be Gen Blac	e of Injury - A	t home, farm, str			20 20,10	28f. Location (Street	and Number or Ru	ral Route Number,
<u> </u>	after after Dire	Certification;	4 Homicide	build	ding, etc. (Spe	cify)	,,,			City or To	wn, Sta	ate)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 18 Certifying I	Physician: To th	ne best of my k	nowledge, deat	h occurred a	t the tim	e, date and place,	and due to the	cause	(s) and manner as	stated.
	the Ho in 24 the Fu	edicai	one)	and ma	nner stated.	ination and/or in				red at the time,		ind place, and due	
	To T To 1	Σ	29b. Signature and title of certifier	1 /	(100	/ 1	29c.	License	3 8 76	7		Date signed (Month	
	. *		Sharn	11. hr	-		2					06-2:	
	10		30. Name and address of person who	o completed cau	use of death (I	tem 23a) (Type, る <i>clc Mr.</i>	Print)	-411	0/d 1	-roder	ick	Red Sui	te 18
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sig	gnature			Ba	Himo	4	Md. 3	1237
	Registr		IIN 9 7	2006	Calles .	11. A	melle						
		_			The Party of the P	47 -							

Physician	1.	Decedent's Name (First,	Middle, Last) ROSIA		BURK	E (GRAY				2. Date of D Month JUNE	Day	200	/
/Medical Examiner		I. Facility Name (If not in:	stitution, give s	treet and num			4b. City,	Town, or	Location	of Death	V		County of De	-
uneral director	_	Social Security Number 226–38–3972	6. Sex		7. Age (In yrs.	last birthday) 5 Yrs.	If Under Months	,,,,,	If Under Hours	24 Hrs. Min.	8. Date of 8	lirth Day, Year)	9. 8	Birthplace (State or Fo
>		sual Residence of Deced				ty. Town or Lo	cation				100 22	, 1,5		10d. Inside City Li
fled at	1,		TIMORE	COUNT		OWINGS		S						1 □ Yes XX
to or 28e-1 ell be rolllied	10	9909 MIDDI	E MILL	S DRIVI	E		10f. Zip		117				zen of What JSA	Country?
to Health and Mahala Hyghen and It it is a 27 is marked other than "naturet, or litems 23a or 28e-f ehov or other treumstic event, the Medical Examinar must be notified at or other treumstic event, the Medical Examinar must be notified at To Be Completed by Funeral Director		1. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 A D	☐ Married	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	2 À No ∕9		Was Deced f Yes, spec	rty Cuba	spanic Or n, Mexical Specify:	n, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - A Black, W Specify.BL	
yglene, nature t, the Medical E		15. Do (Specify only Elementary/Secondary (ecedent's Edu highest grade 0-12)	cation e com <i>pleted)</i> College (1	-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us EDUC	rk done d se retired	during mos)	st of work	ing	ATL	nd of Busine ANTA, LIC SC	GEORGIA
and Menial Hyglene. Is marked other then sumatic event, the M. To Be Comp	1	7. Father's Name (First, I							18. Moth		First, Midd.		Sumame)	
th and w 7 to mar treumat		9a. Informant's Name/Re JANICE BAR		pe, Print) (COUSII	N)		ng Address ON WA		and Numb		al Route Num		r Town, State	e, Zip Code)
nt of Health :: If Item 27 I	2	0a. Method of Disposition	nation 3 🗆 R	lemoval from	State	Place of Dispo cemetery, crea	natory or of	ther plac			Date .5-06			or Town, State
Department of Hiller III flee eny Injury or oth once.	2	4 ☐ Donation 5 ☐ Donation 5 ☐ Construction 5	-		, mio	7-	Name an	d Addres	s of Facili	INERA	L HOME LAMSBU	3		
on and Medical aminer Examiner		23a. Part1. Enter the dises shock, or heart failur mmediate Cause (Final disease or condition esulting in death) Sequentially list condition any, leading to immedia ause. Enter Underlying Jause (Disease or injury hat initiated events	e. List only or	Due to ((or as a consec	LL C	ELL				NCER			Approximate Interval Betwee Onset and Deal
physicie the bur dicai		F FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	ant	dd. 23c. If yes, out 1 □ Live b	(or as a consection of pregnish 2 ☐ Feta ant at time of cown	ancy al death 3[□Ectopic pr						23d. Date of Month	delivery Day Year
signed by the e	F	art II. Other significant	conditions cor	ntributing to de	eath but not res	sulting in the u	nderlying c	ause givi	en in Part	I.	1	tobacco u		e to the cause of death
cele has been signed by the eltending page 2 should be detached for use as Completed by Physician/Me											24a. Wa	as an topsy rformed?	24b. Were	autopsy findings avai to completion of cause 1?
his certificate il director, pag To Be Col	2	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No		Hospital:	npatient 2] ER/Outpatie	nt 3 DO	Oth	00		n <i>Check onl</i> me 5 ☐ Re		6 □Other (S	Specify)
		7. Manner of Death TNatural 5 ☐ 2 ☐ Accident	Pending investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injun Work	yat k? Yes 2 ⊑		28d. Describe	e how injur	y occurred	
rs after death. I Director: After the in by the funera Certification;		3 Suicide 6 4 Homicide	Could not be determined	28e. Place buildi	of Injury - At h ing, etc. (Speci	nome, farm, st	reet, factory	, office				(Street an own, State		Rural Route Number,
thin 24 hours the Funere impletely tille		29a. Certifier 120 (Check only 2 N	Certifying Phy ledical Exami	ner: On the b	e best of my kn asis of examin- ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin , in my o	ne, date a pinion, de	nd place, ath occuri	and due to the	e cause(s) e, date and	and manner I place, and o	as stated. due to the cause(s)
로 <u>후</u> 글 교		29b. Signature and title of	certifier		N	17	290	0	e number			29d. Da	1	onth, Day, Year)
To To		1× QM	ich A	lorg	. ['	117		KE	5-0	00		61	10 0	1606

CHARLOTTE MARIE GOETSCHIUS

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5

2. Date of Death

Day

2006

3. Time of Death

Α

9:57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

26, JUNE 4c. County of Death 4b. City. Town, or Location of Death WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 11/20/1918 NEW YORK 10d. Inside City Limits 1 XYes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry AGRICULTURE 18. Mother's Name (First, Middle, Maiden Surname) DASSOW CAROLINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199 TOPEG DR., SEVERNA PARK, MD 20c. Location - City or Town, State SUFFERN, NEW YORK 22. Name and Address of Facility FLETCHER FUNERAL HOME MAIN ST., WESTMINSTER, MD Approximate Interval Between Onset and Death @ internal Jugular = Subdavian. 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ ₩nknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2000 1 Yes 2 40 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 039502 MA 447 E. MAIN ST., WESTMINSTER, MD. 21157

State Registrar 29b. Signature and title of certifier

SYED HOSAIN,

31. Date filed (Month, Day, Year)

deser & Goods

Amend item#5, perFn, 356,6/27/06 TT State of Maryland / Department of Health and Mental Hygiene 0 6 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** P^{M} Mary Ellen 2006 Gi 11 June 16, 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Madonna Heritage Jarrettsville Harford 5. Social Security Mumber If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec. 2, 1 Birthplace (State or Foreign Country)
 OH 7. Age (In yrs. last birthday) **Funeral** Days Hours 181 M 2 1 X F 297-18-5167 Yrs. Director 82 Dec. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show ral', or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Harford Abingdon Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2861 Browning Court 21009 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 Secretary Wittenberg University permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Reynard Margaret Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Benston/Daughter 2861 Browning Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place Newcomers Cemetery 20a. Method of Disposition June 22, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) 2006 Springfield, OH 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. PAdonia Road Timonium, MD 21093 21. Signature of Funeral Sec Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Heart chaestive /Medical Due to (or as a consequence of): Examiner CYON QVU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 000 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 20 1 Yes 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 No Other 4 ursing Home 5 Residence 6 Other (Specify) P 1 Tes 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print) 754 Hickory Ave. Belair, MD 21014 Kevin Snyder, M.D. 32. Revistrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUN 2 Registrar

			For State Registrar	State of Ma	aryland.		irtment of I tificate of		l Mental H	ygiene Reg. No	C U U I	5	20087
			1. Decedent's Name (First, Middle, Las	st)					2. Date of I	Death			3. Time of Death
	Physicia /Medic		William Lo	uis Gei	174C				June	Da		: 6	1:21 AM
y.	Examin		4a. Facility Name (If not institution, give		•			or Location of De	ath	4c.	. County of D		
			Baltimure VA				If Under 1 Year	If Under 24 H	re 0 Data at 1	2:45	NII		(0)
ī	Funeral Director		5. Social Security Number 6. S 6. S 1	M 2□F	(In yrs. last	Yrs.	Months Days	Hours Mi	n. (Month,	Day, Year)		Country	ce (State or Foreign y)
			Usual Residence of Decedent						Sept.	19,1	932	MD.	
	arylan ahow		10a. State 10b. County	imore	10c. City, T	fown or Loc ndalk						10d	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	8a-1.	Director		THOLE		IIUalk				T			
	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avant, the Madisal Examinar must be notified at	ai Dir	10e. Street and Number 11 Roseview Roa	ıđ			10f. Zip Code	1222		10g. Cit	tizen of What USA	Country	y ?
	tama tama	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	14. Race - A Black, W		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □XYes 2 □ N If Yes, Give Year or Dates:	10	1	I□Yes 2X No	Specify:			Specify:	Whi	te
21215-0036	2 hou	ed	15. Decedent's Ed	ducation	1	16a. Deced	lent's Usual Occu kind of work done	pation		16b. K	ind of Busine	ss/Indus	stry
215	hin 72	Completed	(Specify only highest gra	ade completed) College (1-4or 5		life. L	OO NOT use retire	d)	vorking		Ctool		
2	filed wit Hygiene ther the	Con	12 yrs.			Ste	el Worke				Steel		
nd	be file	Be	17. Father's Name (First, Middle, Last)						lame (First, Midd				
Z	should ind Men marka umatic	10	Joseph P. Geor	-		10h Mailin	- Address /Ctors	L	a Bella			- 7:- 0	\
Maryland	id 2 si ith an 27 is r		William Earl Ge	•			g Address (Stree Rosevie					e, zip C	ode)
	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other pla	ical	Date	20c. L	ocation - City	or Towr	n, State
Ē	Page nent o nt: If		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1		Cremator	Juli	ne 26 2006	Ba	altimor	re	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		21. Signature of Funeral Service Lice	200 D	001		Name and Addr nnelly F		Home Of		alk		
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused	the death.	71 Do not ente	10 Solle	rs Point	E Rd. 21	222		A	Approximate
	Dhamisisa		Immediate Cause (Final	one cause on each lin	18.	. T.	tic K	1.1.				Ir	nterval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	aDue to (or as a			100	05/00	CHUC	1000	~		
	Examiner		Comments the line and this are	, 01	Pine	1	1 the						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequer	ice of):							
3.	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	> 0 00		CHER	•					
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687		edical		_ d.								+	
Box	death certific e attending p d for use as	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome)C-4i-				23d. Date of	delivery	,
	a deati	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at]Ectopic pregnanc] Other (s <i>pecify</i>) _	:y		-	Month	D	ay Year
P.0	that the de ned by the a detached t	Phy	9 Unknown				40.4	St. p	20- 0	4 4 - 4			
Records,	law requires tha as been signed i 2 should be det	ed by	Part II. Other significant conditions of	contributing to death bu	ut not resulti	ng in the ur	iderlying cause gi	ven in Part I.		TYes 2	_	Probab	cause of death?
eco	has bei	Completed							24a. W	as an topsy	24b. Were	autops	sy findings available pletion of cause of
<u> </u>	∓. eag	Con							pe 1 ☐ Yes	rformed?	death	1? (es 2	
Vital	Physician: Tribis certificate director, pr	Be	25. Was case referred to medical examiner?	Hasaitali.					eath (Check onl	y one)			
of	S S D	<u>۲.</u>	1 Yes 2 No		ent 2 EF	VOutpatien Bb. Time of	1 3 DOA		Home 5 ☐ Re			Specify)	
O	ftel	tion	1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injur (Month, Day	y Year)	Injury	Wo	ork?]Yes 2∐No	200. Describ	e now inju	ry occurred		
Division	Attending or death.	Certification:	3 Suicide 6 Could not b	28e. Place of Inju		e, farm, str						Rural F	Route Number,
	ital or rs efte at Dir led in	Cert		building, etc	c. (Specify)				City or	Town, State	=)		
	To the Hospital or Atlandi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	hysicien: To the best of miner: On the basis of and manner sta	f examination	edge, death n and/or inv	n occurred at the t vestigation, in my	ime, date and pla opinion, death or	ace, and due to the courred at the time	ne cause(s e, date an) and manner d place, and	as state due to th	ed. he cause(s)
	To th withir To th comp	Me	29b. Signature and tille of certifier				29c. Licen	se number		29d. Da	ite signed (M	onth, Da	ay, Year)
			Ben K.	John	1	Q-	Da	rore		06	123	10	6
	Q		30. Name and address of person who									•	
			31. Date filed (Month, Day, Year)	~ Ko EF	ar's Signatur	C.	10	N,	Cucer	2 51	L	21	50(
	Sta Registi		31. Date filed (Montin, Day, Year)	A.	ar o signatur	K. A	berle						

ORIGINAL

		ľ	1 - For State Registrar	State of Marylan		artment of H			ene . No 2006	20088
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		George	Travers	G i lm	ore		Month June	22, 2006	1:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
3		0	207 W. Seminary	Avenue			erville		Baltim	
1	Funeral		5. Social Security Number 6. Sex	M 2DE	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	 Date of Birth (Month, Day, Y 	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	7	9 Trs.			June 17,	1927 Ne	w York
	land ow	1	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 eh	ţō	Maryland Baltimor	e lu	thervi	11e				1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	ountry?
	h with	D E	207 W. Seminary Av	renue		21093	3		U.S.A.	
	deal	ner		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or It	by Funeral Director	1 ☐ Never Married 2 ☐ Married	1 X) Yes 2 □ No If Yes, Give 1,945-1 Year or Date1.		1 ☐ Yes 2 X OXNo	Specify:		Specify:	
8	72 hours after death with the Maryland Insture!; or Items 23s or 28s-f ehow dical Examinar must be routilist at	d b	3 Widowed 4 Divorced		, ,	dent's Usual Occup	ation	16	Sb. Kind of Business	White
1 5-	n 72 "nat	Completed	(Specify only highest grade	e completed)	(Give	kind of work done of DO NOT use retired	during most of working	g	D. KIIIO OI BUSIIIess	madsay
12	within iene. then "	Lio Lio	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Phy	sician			Medicine	
Maryland 21215-0036	at Hygir other	Be C	17. Father's Name (First, Middle, Last)			JIOIAN	18. Mother's Name	(First, Middle, Ma		
<u>a</u>	Mental Mental rked c	To B	George D.	Gilmore			Margar	et	Travers	
ary	2 should be and Ment le marked raumatic e		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	and Number or Rural		City or Town, State, 2	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other then "nature!, or items 23a or 28a-f show other traumatic event, the Medical Examination in the Landley at		Jeanne Gilmore	Wife						ryland 21093
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ P		lace of Dispo emetery, crea	osition (Name of matory or other place		ate 20	c. Location - City or	Town, State
Ĕ	Pag ment ant: I ury c		Donation 5 Other (Specify)	Hil			orp. 6-26-	2006 T	owson Ma	aryland
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		21. Signature of Funda Ferrica Licens	000	2:	2. Name and Addres	Nu	ck Towso owson, M		Home, Inc. 21204
Н			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	h. Do not en	ter the mode of dyin	g, such as cardiac or	respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		(m)	on /	ancen			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):					Jeans
	Examiner		Sequentially list conditions,	D						
	Pi is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of).					
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uanca of):					
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387	physicate by the t	dical		d						
9 x	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	ivery
Box	atter of for L	ciar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	'		Month	Day Year
0	that the de ed by the a detached	nysi	9 Unknown	9□ Unknown						
ds, P	8 5 6	by	Part II. Dther significant conditions con	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	1	o the cause of death?
Vital Record	w require been si should a	Completed						24a. Was an	24h Were at	utopsy findings available
Re	The lav	m d						autopsy performe	prior to death?	completion of cause of
a		ပိ	25. Was case referred to medical				OC Plans of Dooth			2 No
⋚	Physiclan: this certific ral director.	o B	examiner?	Hospital:	ER/Outpatie	nt 3□ DDA Oth	er: 4 Nursing Hor		ce 6 ☐ Other (Spe	cifu)
o	g Phy er this	H	27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c, Injur	y at 2	8d. Describe how		ony)
<u>ö</u>	Attending Indeath. ctor: After by the funer	atio	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1	Yes 2 □No			
Division	l or Attendiater death. Director: A	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, st	reet, factory, office	2	8f. Location (Stre	et and Number or Ri State)	ural Route Number,
Ö	s afte al Dir	Certification:		January, other (opposite						
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deal stion and/or in	th occurred at the tir evestigation, in my o	me, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the Within Fo the	Me	29b. Signature aportitle of certifier	11		29c. Licens	e number	290	d. Date signed (Mont	h, Day, Year)
	, , , ,		Heel 110	lan n	2	2	30929		6/23/2	2066
أز	intly		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type	Print) /	1 0:-	0 -) > '
4	N.01		PAUL Celan	0,100 A536	1 10	Men	of ST,	BALT	mere In	121204
4		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature				1	/
372	Regist	rar	JUN 2 7 200	5 Ellengue D	ROLL GOL	us.				

			1 - For State Registrar		of Maryla	-	artment of rtificate of				eg. No.	005	210	089	
	Physicia	an	Decedent's Name (First, Middle,		0				2	Month Month	Day	2006	3. Time o	Death M .	
	/Medic		Willia: 4a. Facility Name (If not institution,		Gray		4h City Towr	n, or Location o	of Death	june	4c. C	ounty of Death	1.25		
	Examin	er	Baltimore Washi			enter		Burnie	. 504			ne Arun	ide1		
	Funeral		5. Social Security Number	6. Sex	_	a. last birthday,	If Under 1 Ye	ar If Under		. Date of Birth			place (State ntry)	or Foreign	
	Director		577-16-8965	1 ∑ M 2□F	83	Yrs.	Months Day	ys Hours	Min.	Month, Day,	192	2	Mary	1and	
	p .		Usual Residence of Decedent		110.0									22	
	srylar	_	10a. State 10b. County		100. 0	City, Town or L	ocation						10d. Inside (s 2 No	
	Ba-f	Director		Arunde1		00	denton				00	411111111111111111111111111111111111111		2 2 3 110	
	with th		10e. Street and Number		. "00		10f. Zip Cod			1		on of What Cou	-		
	er death with the Marylan Items 23a or 28a-f show permet be notified at	erai	2495 Amber Orc				211		gin? (Specif	fy Vac or No-		ited St			
36	E o at	by Funerai	11. Marital Status 1 □ Never Married 2 1 Marrie 3 □ Widowed 4 □ Divorced	ed 1 1 Yes	cedent Ever in Forces? 2 No Bive Dates: 1942		Was Decedent of If Yes, specify C		n, Puerto Rio	can, etc.)		Black, White,	etc.		
21215-0036	n 72 hours "natural", edical Exa	ed	15. Decedent	s Education		16a. Dece	dent's Usual Oc	cupation		-	16b. Kind	of Business/In			
715	nin 72 In "na	Completed	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work do DO NOT use re	ne during most tired)	t of working	'					
212	d within giene. rr than "	E O	12th	Conege	(1-401 5+)	C1a	aims Man	nager			Life	Insura	ince C	ompany	
Pu	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, L	.ast)				18. Mothe	er's Name (/	First, Middle, I	Maiden Si	ımame)			
<u>la</u> ı		2	Clarion Clyd	e Gray				Elia	zabetl	h E11i	ott	Chase			
Maryland	s 1 and 2 should I Heelth and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationsh	ip (Type, Print)			ing Address (Str						127.00		
	1 and 2 Heelth am 27 thar tr		Marie Main Gray	/wife	1		Amber C	-		The state of the s				d21113	
ore	ges 1 al t of Hee if itam or otha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from	1	Place of Disp cemetery, cre	osition (Name of matory or other	place)	Dat	e	20c. Loca	ition - City or To	own, State		
Ē	Pag ment ent: ury c		4 □Donation 5 □ Other (Sp	ecify)	We	st Aru	ndel Cre	matory	6/24/2	2006	Oden	ton, Ma	ırylan	d	
Baltimore,	permit. Pages. Depertment of the Important: If its any injury or of once.		21. Signalure of Funeral Service L	Donaldson Funeral Home & Cr											
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not en	ter the mode of	dying, such as	cardiac or r	espiratory arr	est,		Approxima Interval Be	etween	
	Physician		Immediate Cause (Final disease or condition	A	to 1	muel	no 6	when	nnA	•			Onset and	Death	
1	/Medical Examiner		resulting in death)	Due to	o (or as a conse	equence of):			•						
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	ate be executed only sicien and the fire the burial-transit	хап	that initiated events resulting in death) Last	c. Due t	o (or as a conse	adulance of):									
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	phys phys the	dlc		d											
9 X	The law requires that the death certific ate has been signed by the attending pl page 2 should be detached for use as	Physician/Medical	IF FEMALE:	23c. If yes, c	utcome of preg	nancy					22	d. Date of delive	00/		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	tal death 3	□Ectopic pregna □ Other (specify				23	Month	Day	Year	
o.	at the de by the	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk				/							
<u>α</u>	res that the signed by be detact		Part II. Other significant conditio	ns contributing to	death but not re	esulting in the u	underlying cause	given in Part 1.		23e. Did tol	bacco use	contribute to t	he cause of	death?	
of Vital Records,	uires s sign ld be	d by								1 🗆 Y	es 2 X	No 3 □ Prot	bably 4]Unknown	
00	v requir been s should	Completed								24a. Was a		24b. Were auto	nosy finding	s available	
Re	he lav	m								autops perforr	v	prior to co death?	mpletion of	cause of	
a		e Cc	25. Was case referred to medical					00 01			/ ` 	1 🗆 Yes	2 No		
⋚	Physician: this certition ral director, i	00	examiner?	Hospital: 15	Inpatient 2	☐ ER/Outpatie	nt 3□ DOA	Othor		Check only on		☐Other (Specif	6.1		
	ਰੂ ਵੇਲੂ	To To	27. Manner of Death	28a, Dat	e of Injury	28b. Time (III JU DON	njury at Work?		d. Describe ho			у)		
o	th. : Atter	tion	1 Natural 5 Pending 2 Accident investig		nth, Day Year)	Injury		Work? 1 ∐ Yes 2 ∐ I	No						
Division	Attanding r death. actor: Alter by the funer	Ifica	3 Suicide 6 Could n	ned 286. Plac	ce of Injury - At	home, farm, si	treet, factory, offi	ice	28			Number or Rura	al Route Nur	m <i>ber</i> ,	
Ö	efte Dire	Certification:	4 Homicide	buil	ding, etc. (Spec	city)				City or Town	n, State)				
	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely tilled in by the fo	edical (29a. Certifier (Check only one) Certifying Medical B	g Physician: To the Examiner: On the and ma	ne best of my ki basis of examin	nowledge, dea nation and/or in	th occurred at the	e time, date an ny opinion, dea	d place, and th occurred	d due to the ca at the time, d	ause(s) ar ate and p	nd manner as s lace, and due t	tated. o the cause	(s)	
	To the within 2 To the complet	¥.	29b. Signature and title of certifier		-		29c. Lic	ense number				signed (Month,			
	-		1 Asuta		mo		D	4357	7		Inno	22	2001		
3 11	10+1		36 Name and address of person of the second	who completed ca	use of death (Ite	em 23a) (Type	Print) L.	glan	Sim	ue. 1	م	2106	1.		
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's sign	dature do	les	1							

DHMH 17 Rev 1/2001

WILL AM GRAY

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b, perily C856 6 77/06 TT/ Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month 2006 **Physician** 8:20 Gromyko Jone 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1**⊠** M 2□ F 12.02.1958 216.68.6819 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ir Items 23a or 28a-f ehow drier must be notified at 1 XYes 2 ☐ No BALTIMORE Director MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number usa21229 ROAD 3801 ROKEBY o filed within 72 hours after death val Hygiene.
other than "natural", or Items 23s by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🕰 No Baltimore, Maryland 21215-0036 Specify. traumatic evant, the Medical Exer-3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)

A VRS Elementary/Secondary (0-12) COUNSELOR MD STATE 12/14 GRADE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avents. 17. Father's Name (First, Middle, Last) Be HUNTLEY SR. ARDEUA WILLIAM WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 100 S. HILTON 3807 Rokeby Road Baltimore, MD 21229 ST. MOTHER ARDEUA WILSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07-01-06 BAUTMORE, MD 4 □ Donation 5 □ Other (Specify) WOODLAKIN 22. Name and Address of Facility FUNERAL SERVICE VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licenza 5151 BAUD. NATU PIKE, BAUD. MD 21229 vaustin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final Physician. disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** pyeumonia Sequentially list conditions, for leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan hes autopsy performed 2 100 1 Yes 2 1 No 1 Yes To the Hospital or Attending Physician: 26. Place of Death | Check only one 25. Was case referred to medical Other: 4 Nursing Home Hospitaf: 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA 5 Residence 6 Other (Specify) tor: After this c Certification: To 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sutcide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saint Paul

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Place

Baltimore, MD

30

37. Registrar's Signature

		For State Registrar	Sta	ite of M	larylar	nd / Depa		ent of H		and M	ental Hy	giene Reg. No	201	16	20	091
Div. day		Decedent's Name (First, Middle	, Last)								2. Date of De			rear	3. Time o	of Death
Physicia /Medic		RUTH D.	HAYS_										200		6:08	3 A M
Examin	er	4a. Facility Name (If not institution	, give street a	and number,)		4b. C	ty, Town, or	Location o	of Death			. County of			
		Gilchrist 5. Social Security Number	Cente 6. Sex		00 /la ura	last birthday)	if I In	TOWS		24 Hre i	0. Data of Di		Balt.			
Funeral Director		219-05-1933	1 □ M 2		90 (<i>III yi</i> 5.	• • • • • • • • • • • • • • • • • • • •	Month		Hours	Min.	8. Date of Bir (Month, Da 12/8/	ay, Year) 1916	9 1	Coun	lace (State ltry) vlanc	-
		Usual Residence of Decedent									12/0/			1al)	/ Lanc	
arylan show	_	10a. State 10b. County			10c. Ci	ity, Town or Lo								11	0d. Inside (•
Se-f	ecto	MD.				Balt					T					s 2 No
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other than 'natural', or iteme 23s or 28s-f show event, the Madical Examinst must be notified at	Funeral Director	10e. Street and Number 3124 E. Nort	nern 1	Parkw	72 W		10f.	Zip Code 212	1 4				tizen of Wh ted			
ne 23	era	11. Marital Status		s Decedent		J.S. 13.	Was De			nin? (Spe	cify Yes or No		14. Race			
after of lines	Fun	1 ☐ Never Married 2 ☐ Marr	ied 1	ned Forces']Yes 21⊘]	?					, Puerto F	cify Yes or No Rican, etc.)		Black,	White,	etc.	
ours a	a py	3 Widowed 4 □ Divorced	I II Y	es, Give 15 ar or Dates:			1 L Yes	2 X No	Specify:				Specify:	Whi	te	
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withir than	dw	Elementary/Secondary (0-12)	Col	llege (1-4or	5+)			use retired, cetar	,			Мо	tion	Ρi	ctur	e
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Med of the state o	To Be	Walter J. Da	ahle						Es	tell	a M.	Her	get			
s 1 and 2 should be filed within the Hath and Menial Hygiene. Ifem 27 is marked other than other traumatic event, Ira Ma		19a. Informant's Name/Relations				19b. Mailir	ng Addre	ess (Street a	and Numbe	r or Rura	l Route Numb	er, City o	or Town, St	ate, Zip	Code) 2	0678
and 2 ealth a m 27 le		Joann Dahle/	Niece	9		4400	Sc	outh	Shore	e Dr	. Pri	nce	Fre	der.	ick,	Md.
Pages 1 nent of He int: If Iten		20a. Method of Disposition 1	3 □Remova	ıl from State		Place of Dispo cemetery, crer	natory c	r other place	9)		ate		ocation - C	-		
permit. Pages I Department of H Important: If Its eny injury or ot ance.		4 ☐Donation 5 ☐ Other (S	oecify)		Pai	rkwood			- ,					-		
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		shock, or heart failure. List	only one caus	se on each I	line.	P -	91 (119 11	/ a	g, such as t	Lardiac or	/ / / / / / / / / / / / / / / / / / /	rrest,			Approxima Interval Be Onset and	tween
Physician /Medical		disease or condition resulting in death)	a	Oue to (or as	ng	LAV.	ve	nea	N	1 a	ilu			-	jea	~
Examiner				A		tuerice (i).	54	2	ze'	7				0	1ea	n
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. —	Due to (or as	a consec	quence of):								1]	
acuted ind transi	Examiner	that initiated events	c													
		resulting in death) Last		Due to (or as	a consec	quence of):										
th chy	dicai		d											-		-
eath certific attending p	ian/Med	IF FEMALE:	23c. If y	es, outcome	of pregna	ancy							22d Date :	a da li un		
death atter	0	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1]Live birth]Pregnant a	2 Feta	al death 3	Ectopic Other	pregnancy (specify)					23d. Date of Month		-	Year
the de by the	hys	9 Unknown	9□	Unknown				. ,,								
- g - p g	by P	Part II. Other significant condition	ns contributin	ng to death b	out not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco u	use contrib	ute lo the	e cause of	death?
w require been sig should b											10	Yes 2	No 3	☐ Proba	ably 4 🗆	Unknown
lawr es be 2 sh	Completed	/.									24a. Was		24b. We	re autop	sy findings	available
The I	50										perfo	rmed2 2 No	098	th? Yes		cause of
yslcian: Th	Be	25. Was case referred to medical examiner?	Hospital					0"	-		(Check only o				-11	
. S S S	ဥ	1 Yes 2 No		1 U Inpati		ER/Outpatien			4 🗀 7 101		e 5 Residente la R				1100	pici
ding Ih. Th. After tuner	ţ	1 SNatural 5 Pending 2 Accident investig		Date of Inju (Month, Da	y Year)	Injury	М	28c. Injury Work	ai ? ′es 2⊡N		ed. Describe i	iow injur	y occurred		0	
Attend r death ector: A	ifica	3 ☐ Suicide 6 ☐ Could r	ot be	Place of In	jury - At h	ome, farm, stre	eet, fact				8f. Location (Street an	d Number	or Rural	Route Nun	nber,
s afte s afte el Dir	Certification:	4 Homicide determ		building, e	tc. (Specil	(y)					City or To	vn, State))			
	edica	29a. Certifier 1 Certifyin (Check only one)	g Physician:	To the best	of my kno	wledge, death	occurre	ed at the time	e, date and	place, a	nd due to the	cause(s)	and mann	er as sta	ited.	
To the P within 24 To the F complete	Med	50,	and	d manner st	ated.					II OCCUITA						
To To Con		29b. Signature and title of certifier		1	0	0	2	9c. License			I .		te signed (/			
~		20 No. 1	n-	1 K		2000		1)	300	, 1		JUY	102	5, =	1006	
10		30. Name and address of per on	o complete	cause of c	peath (Mér	n 23a) (Type, I	Print)	N	Ca	all.	- J).	B	a Cy	de	131	206
Stat	e	31. Date filed (Month, Day, Year)		32 Registr	rar's Signa	ature					. 0,					
Registra		HIN 9 7	2006	1000	/	X PAN	Sec.									

Obosam

			1 - For Stete Registrar	State of	Marylar		artment o			lental Hyg	iene _{eg. No.} 20	06	20092
	Physici /Medic		Decedent's Name (First, Middle,	Walter		epner				June 22	, 2006	Year	3. Time of Death 10:47 A M
*	Examin	er	4a. Facility Name (If not institution, Gilchrist Cer		iber)		4b. City, Tov	vn, or Location Towson			4c. County		ltimore
	Funeral Director		213-48-0711	3. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	8. Date of Birth Month, Day, JUL 20,	1950	9. Birthp Coun III	lace (State or Foreign try) LNO1S
Maryland 21215-0036	r 28e-f ehow	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Balt 10e. Street and Number	imore	10c. Ci	ity, Town or Lo	Hyde			1	Og. Citizen of V		0d. Inside City Limits 1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23s or 28s-1 show any injury or other treumatic event, the Madical Examinar must be notified at ances.	Completed by Funeral Director	5905 Church La 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed For	ces? 2 [X]No 9	-	Was Decedent If Yes, specify			ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White		
	ed within 72 hou ygjene. ier than "nature t, the Madical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	grade completed) College (1-5+	4or 5+)	(Give	dent's Usual O kind of work d DO NOT use ro ical Do	one during mo etired) OCTOT		ing	16b. Kind of Bu	e Pr	
yland	ould be file Mental Hy harked oth	To Be	17. Father's Name (First, Middle, Last) Walter Ray Hepner, Jr. 18. Mother's Nam Jean										
	es 1 and 2 sh of Heelth and I item 27 ie m r other treum		19a. Informant's Name/Relationshi Kathryn Yamamot 20a. Method of Disposition 1 □ Burial 2 □ Tremation	co/Wife	20b.	5905		n Lane	Hyde	es MD 2 Date			
Baltimore,	permit. Pag Department Importent: f any injury o		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	ecify)		22		ddress of Faci	lity Cre	3/06 emation Baltimo	_	of	MD, Inc.
	Physician /Medical		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cannot one cause on ea	e land	oma	er the mode of	dying, such a	s cardiac o	or respiratory arm	e <i>s</i> t,		Approximate Interval Between Onset and Death UNDVIUS
68760,	ate be executed whysicien and the burial-transit	Ical Examiner	Sequentially list conditions, Lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conse								
.O. Box 68	death certific e attending p id for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetant at time of	al déath 3	Ectopic pregn Other (specif				23d. Dat Mor	e of delive	nry Day Year
S, D	The law requires that the ste hes been signed by th bage 2 should be detache	þ	Part II. Other significant condition	s contributing to de	ath but not re	sulting in the u	nderlying caus	e given in Part	1.	23e. Did tot			e cause of death?
al Record	The lar	Completed						227		24a. Was a autops perform	ned? c	Vere autoprior to con leath?	osy findings available inpletion of cause of
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificele completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could no	М	Other: 4 No North North?	lursing Ho	me 5 Reside	ence 6 XOthe ow injury occurr	ed				
Divi	lospital or Attend I hours after death uneral Director: ,	Certifi	4 Homicide determin	ify)	n, street, factory, office 28f. Location (Street and Number or Rura City or Town, State)								
	To the Hospital of within 24 hours a To the Funeral Completely filled in	Medical	29a. Certifier (Check only one) 2 ☐ Medical E 29b. Signature and title of certifier	Physician: To the xeminer: On the ba and mann	sis of examin	ation and/or in	vestigation, in	ne time, date a my opinion, de cense number	ath occurr	ed at the time, d	ate and place, a	and due to	the cause(s)
)	₹ ₹8		▶ Allan	luis	a of doosts (II-	m 224) /T	1	583	03		JUNE	22/2	006
	10			MUES, MI) 660	OL N. C	herles	S+ BA	Thre	e Mo	21204		
	Sta Regist		31. Date filed (Month, Day, Year)	006	egistrar's Sign	A	ule)						

			For State Registrar	State of Mary	land / De	partment of H	lealth and M	lental Hyg	iene 200 (5 20093
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physicia		Iva Ideli	a	Hale			June	Day Year 25, 2006	5:45A ^M
	/Medic	_	4a. Facility Name (If not institution, give		HALC	4h City Town or	Location of Death	Julie	4c. County of De	
	Examin	er				_				
_			Morningside House 5. Social Security Number 6. Se		NIP yrs. last birthda	Hanc	over	8 Date of Birth	Anne A	
	Funeral		213–20–9866	M 22 F	92 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 14	, 1913	irthplace (State or Foreign Country) MD
	Director	1	Usual Residence of Decedent		72			NOV. 14	, 1913	עודו
	and w	ı	10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Many f	5	MD Anne Arun	del d	len Bur	nie				1 ☐ Yes 2 X No
	10 P	Director	10e. Street and Number	ide1	Ten bar	10f. Zip Code		1,	Og. Citizen of What (Country?
	with P or	늅				·		,		ountry :
	eth .	Funeral	404 Sycamore Lane			21061			U.S.A.	
	ar de	une	11. Marital Status	12. Was Decedent Ever Armed Forces?	'in U.S. 1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
9	or l		1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:	White
Ö	within 72 hours after deeth with the Maryland ene. than "neturet", or iteme 23s or 28s-f ehow he Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:						
Ŋ	72	ete	15. Decedent's Ed (Specify only highest grad		(G	cedent's Usual Occupative kind of work done	during most of work	ing	16b. Kind of Busines	s/Industry
2	ithin	교	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retired	"			
7	filed w Hygier other tf	S	9		F	lomemaker			Own Home	2
5	be fill ital Hy od oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
Maryland 21215-0036	uid t Ment rrke tfc	2	Turner Watson				Lula Up	ton		
a	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Importent: if item 27 is marked other than "neture!", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examination mat be notified at one.		19a. Informant's Name/Relationship (T	/pe, Print)	19b. M	ailing Address (Street a	and Number or Run	al Route Number,	City or Town, State	Zip Code)
	nd 2 alth a 27 is		Mr. Samuel E. Hale	/ Husband	404	Sycamore L	ane Glen	Burnie.	MD 21061	
Baltimore,	Hear Hear Hear Hear Othe		20a. Method of Disposition			sposition (Name of crematory or other place		Date	20c. Location - City of	or Town, State
2	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Temovar nom State			100116		C1 P	: - MD
뜵	rtme rtan njur)				Gren na	ven Mem. P			Glen Burn	
a B	Depermination of the permit of		21. Signature of Funeral Service Licens			22. Name and Address		_		Home, P.A.
	40200		1 1000	NO 14		1 Second A				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not	enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	12/2	helm	3/1/200	2 ass			Onset and Death
	/Medical		resulting in death)	aDue to (or as a co			~			
	Examiner		valla on ta transition and a secondarion.	Faile	100 P	E Am	1112			
Ļ		<u>e</u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
1	uted Insit	듣	Cause (Disease or injury							
_	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):					
760,	Ite be executed lysicien and burial-transit	cal								
687	3 3 8			a						
×	leath certific attending pl f for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of p	reanancy					
Вох	ath c	E E	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	3 Ectopic pregnancy			23d. Date of d Month	elivery Day Year
o Ö	e de the a	3	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death	5 Other (specify)				
<u>a</u> .	thet the de ned by the a	£			. 67 1 4			00 5:111		
	res the igned be del	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in th	e underlying cause give	en in Part I.		1	to the cause of death?
בַ	w requir been si should	ed	02 Asserve	2112	-			1 ☐ Ye	s 2	Probably 4 Unknown
Vital Records,	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Completed by	06460 BOB	:25rZ:				24a. Was ar		autopsy findings available
ď	The lav te has age 2	E						autops	ned?// death?	completion of cause of
ā	en:		25. Was case referred to medical			-	26. Place of			5 21110
5	sicili s cert irect	o Be	evaminer?	Hospital:	2 ER/Outpa	tient 3 DOA Othe	n 1/		nce 6 □Other (Sp	
ō	Attending Physicien: The robath. coath. ector: After this certificate hay the funeral director, page	-	27. Manner of Deeth	28a. Date of Injury	28b. Time				w injury occurred	өспу)
5	ding h. Afte fune	盲	1 Natural 5 Pending	(Month, Day Ye	ar) Injur		k? Yes 2 □ No		1-7	
S	ttend death stor:	Ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home form			29f Location /Str	reet and Number or I	Pural Paulo Numbor
Division of	i or Attendente effer deatl	Certification;	4 ☐ Homicide determined	building, etc. (S	pecify)	Street, factory, office		City or Town	, State)	idiai riodie ivanioer,
_	urs e			1						
	Hos 4 ho Fun ely f	edical	(Check only 2 Medical Exam	sician: To the best of minar: On the basis of exa	imination and/oi	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occuri	and due to the ca red at the time, da	iuse(s) and m <i>a</i> nner a ate and place, and di	is stated. ue to the cause(s)
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Med	one)	and manner stated.						
	Vill Con	~	29b. Signature and title of certifier		-	29c. License	rJ ~ Z	29	9d. Date signed (Mor	
)	,		I what is	Sunden	-mo	1)(517		6/26	06
	5		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Ty		0 1	22	0 1	11
			799 1700	ahort	- 05	0901	Sule	. 300) / // Ke	CM, Juino
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature					
	Registr	ar	JUN 2 7 200	6 Reside	# A	parti				
_		-								

				For	State of Mary				lental Hy	giene	nnc	annal.
				Registrar			Certificate of	Death	2. Date of Dea	Reg. No. 🕰	000	3. Time of Death
		Physicia	an	1. Decedent's Name (First, Middle,	Last)		TINES		Month	Day 25	Year	6:45 M
		/Medic		4a. Facility Name (If not institution,	pive street and number)	/		or Location of Death	dune		2co 6	
		Examin	er	St. Agnes		are	Balt	timore			NIA	ł
		Funeral		0 11103		yrs. last birti	nday) If Under 1 Year Months Days		8. Date of Birt (Month, Da)	h v. Year)	9. Birthp	lace (State or Foreign
		Director		219-12-8967	1 □ M 2 🔼 F	88,	rs.		MARCH	16,1918	NORT	H CAROLINA
		and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				1	Od. Inside City Limits
		Maryli fed a	ō	MADWAIN	NIA		BA	LTIMOR	RE CI	TV		1 No 2 No
		1 the 1.28a	rec	10e. Street and Number	,01,1		10f. Zip Code	277.70.		10g Citizen	of What Coun	try?
		h with	al D	1608 N.	PULASKI	STRE	ET	21211	7	6	USA	,
		ems :	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)		lace - Americ Ilack, White,	
	36	or It	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 🖔 No	o Specify:		Spe	cify: B	001
	21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28e-f ehow snt, Ite Madical Examinar must be notified at	ed b	15. Decedent's	Year or Dates:	16a.	Decedent's Usual Occi	upation		16b. Kind of	Business/Inc	dustry
	15	n na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)		(Give kind of work don- life. DO NOT use retir	e during most of work red)	ing			
	212	d with	Eo	6 THGRADE	College (1 401 57)	A	SSEMB		RKER	MD.	BOX	COMPANY
	B	be filed wat Hygie d other	Be	17. Father's Name (First, Middle, L.	ast)	11.		1/8. Mother's Nam	e (First, Middle,			11
	yla	2 should the and Ment le marked eumatice	2	ALBERT		HAR	R15	MARY	/			UGTON
	Maryland	es 1 and 2 should be filed of the strength and Mental Hygies [Item 27 Is marked other? It other treumatic event, It.		19a. Informant's Name/Relationshi		1 -1	Mailing Address (Street	et and Number or Ryr	al Houte Number	ANATE A	vn, State, Zip	Ode)
		1 and Heelth em 27 ther tr		20a. Method of Disposition	TARRIS SISTER-II	20b. Place of	Disposition (Name of		Date	20c. Locatio	on - City or To	own, State
	Baltimore,	permit. Pages of the Department of the Important: If Ite eny injury or of 2002.		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ATIONAL C		21-06	1000	051	MARKININ
	Ä	artme ortan injury		21. Signature of Funeral Service		MO, N	22. Name and Add	Iress of Facility	201.10	TO B	FILLER	ALHOME
	Ba	Departi Departi Import eny inj		1 Diethier	4N. Wille	amo	19,55	N. FULTE	N AVZ	V		1021217
				23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused the	e death. Dor	ot enter the mode of d	ying, such as cardiac				Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition	Toliopa	thec	Dulmos	nan F	ibros	'5		Onset and Death
M		/Medical		resulting in death)	Due to (or as a c	onsequence		9	10,00			,,,,,,,
ES	н	Examiner	L	Sequentially list conditions,	b							
	J	ed sslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence	n).					
	ν_	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence o	of):					
Ž	8760	sicier sicier	dical		d							
1	9	tificate ng phys as the	led									
5	Вох	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy Fetal death	3 □Ectopic pregnar	ncy			Date of delive	ory Day Year
INE		ne deal the att hed fo	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at tim 9 Unknown	e of death	5 Other (specify)				MONTH	Day 18a1
II	P.O.	thet the di ed by the detached	Phy	9 ☐ Unknown Part II. Other significant condition	s contributing to death but r	not resulting in	the underlying cause	grven in Part I	23e. Did t	obacco use c	ontribute to th	ne cause of death?
I	ds,	signed d be del	d by	Hyperty	SCION		, u, u	9.10 1	10	Yes 2□No	3 ☐ Prob	ably 4 Unknown
	Š	v requir been s should	ete	Dilling	P(24a. Was	an 24	b. Were auto	psy findings available
	Rec	he lav e hes ige 2	Completed	Dialbei	<u>C</u>				autor perfo	osy megd?	prior to co death?	mpletion of cause of
	ta	sicion: The certificate rector, pag	a	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes	202No	1 🗆 Yes	2 No
	<u>></u>	ysicle is cert direct	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 / Impatient	2 🗌 ER/Ou	tpatient 3 DOA)thor	ome 5 Resi		Other (Specif	y)
	0 0	ng Ph ter th neral	Di: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. 1	ime of 28c. In	jury at vork?	28d. Describe	how injury oc	curred	
	Siol	endir eath. or: Al	catic	2 ☐ Accident investig	ation			☐Yes 2☐No				
	Division of Vital Records,	fter d	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of Injury building, etc. (- At home, fa (Specify)	rm, street, factory, offic	×e	28f. Location (Street and Nu wn, State)	imber or Rura	il Route Number,
		To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificele hes completely filled in by the funeral director, page 2	1 -	29a. Certifier 1 Certifying	Physician: To the best of r	ny knowledge	death occurred at the	time, date and place	and due to the	cause(s) and	manner as s	tated
		24 hc Fun etely	Medical	(Check only 2 Medical E	examiner: On the basis of examiner states	camination an	d/or investigation, in my	y opinion, death occur	red at the time,	date and place	ce, and due to	the cause(s)
		omple	Me	29b. Signature and title of certifier	emy		29c. Lice	ense number		29d. Date sig	gned (Month,	Day, Year)
		C > E 0		> Basel Al	,60	- M). P2	0283		Ine	125/	2006
"		a		30. Name and address of person	vho completed cause of deal		(Type, Print)	LANCE 2	2 41			
	_	0		BASEL AL	FDKHUTW		00 CAION	AVE.	DALI	MOKE	MO	7212-29
			ate	31. Date filed (Month, Day, Year)		Signature_	Read o					
		Regist	rar	JUN 2 7	LUUD PRESUR	1 15	Part of the same o					

			1 - For State Registrar	State of Maryla		artment of He			iene 200	6 20095
	Dhysici		1. Decedent's Name (First, Middle, L	·			2. Date of Deal Month		3. Time of Death	
	Physicia /Medic			Bartuka Hornb	oarger				26, 2006 Ye	3:09 A ^M
	Examin	er	4a. Facility Name (If not institution, garantee Potomac Valley N			4b. City, Town, or Rocky		1	4c. County of t	
	Funeral				s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Director		224-01-5008	1□M 2対F 89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 17	1916 K	entucky
	and w.		Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	to	Maryland Montgo	mery	Roc	kville				1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
ĺ	23a c		4501 Bayne Stree			208			United S	
	er de:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕱 No	U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
036	urs aft	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	:	1 ☐ Yes 2 🔯 No	Specify:		Specify:	White
ָ ה	72 hor	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	(Give	dent's Usual Occupa kind of work done do	uring most of wor	king	16b. Kind of Busin	ess/Industry
[2]	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) emaker			Own Ho	me.
N 0	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	ပိ	12 17. Father's Name (First, Middle, Las	st)	120111		18. Mother's Nan	ne (First, Middle, I		
an l	should be and Mental marked o	To Be	Frank A. Bartuka				Alic	e Butterv	vorth	
ary	ss 1 and 2 should be of Health and Mental litem 27 is marked or r other traumatic ever		19a. Informant's Name/Relationship			ng Address (Street a				
e où	l and lealth im 27 her tr		Dale F. Hornbarg			Pepper Consistion (Name of	urt, Gei		d 208/4 y or Town, State	
٥			1 Surial 2 ☐ Cremation 3	□Removal from State Hi	ghland	Oublin, Virginia				
			4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service kic		Garden		200 s of Facility			kville, Inc.
ñ	permit. Departimportu		1 Kuf Ja	M001	198 30	0 West Mon	tgomery.	Ave., Roc	kville, M	D 20850-2805
П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de ly one cause on each line.	eath. Do not en	ter the mode of dying	, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. COPGE	STIVE	HEART	FAILU	rce		Oriset and Death
	/Medical Examiner		1	Due to (or as a cons	equence of):					
	î.	Jer	Sequentially list conditions, a y, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Elue to (or as a cons	equence of):					
	acuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	certificate be executed iding physicien and use as the burial-transit	al E	Todaking in oddiny 2000	Due to (or as a cons	equence or):					
687	ficate p phys is the	edical		d.						
Box	eath certific attending p for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnancy			23d. Date of	
	D 0 D	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)			Month	Day Year
9. O.	The law requires thet the de ote hes been signed by the a page 2 should be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death but not r	esulting in the L	inderlying cause give	n in Part I.	23e. Did tol	pacco use contribu	te to the cause of death?
ds,	uires l signe ld be	d by		3.	•	,,				Probably 4 Unknown
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Division of Vital Records,	Phys this al dii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Jane -	☐ ER/Outpatie		Mursing H		ence 6 Other (Specify)
o	ding th.: After a funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	Injury	Work	? ′es 2∐No		,,	
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١	10		30. Name and a dress of person wh			Print)				
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			1_ State	epartment of Health and M Certificate of Death		200b 2009b					
			Registrar 1. Decedent's Name (First, Middle, Last)	Continuate of Boats	2. Date of Death	3. Time of Death					
	Physicia /Medic		Robert Hoteman			3 2006 550PM					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Ic. County of Death					
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И	Funeral Director		18.1.005	rs. Months Days Hours Min.	08703/192	Country) NJ					
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	Maryla f eho	ō		ALTIMORE		1 ☐ Yes 2 [X]No					
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	ath wil	Funeral Director	6703 DARWOOD DRIVE	21209		USA					
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Mar	d 2 shouth and the modern treum			Mailing Address (Street and Number or Rura 703 DARWOOD DRIVE -							
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ë	Pages ment of P ant: If Its ury or o				6/2006	OWINGS MILLS, MD					
Baltimore,	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Service Licensee			ON & BROS., INC. IKESVILLE, MD 21208					
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Вох	thet the death certif ed by the attending detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year					
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	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in 39	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge on the control of the contro	i, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)					
)	1		Christine Kajulu Hospita	list 62912	Ju	une 23 2006					
	10		30. Name and address of persit who is impleted cause of death (ftem 23a) Christine Kolubi 5 401 Deel	Court Road Rai	ndalla	town Maryland					
	Sta			berli		7 7 7					
	Registi	ar	JUIN 6 (LUUD DESERVITOR) SO SO	THE STATE OF THE S							

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** May 18, Eleanor Jefferson 2006 9:30 PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing Home Hvattsville Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Feb 19, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖾 F 85 Director 227-56-2951 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If Item 27 is marked other than "netural", or Items 23s or 28s-f show or other treumstic avant, the Medical Examinar must be notified at MD 1 ☐ Yes 2 ☑ No Director Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4922 Lasalle Road 20718 Funeral USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 and 2 should be filad within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk | 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Depertment of Health as
Important: If Item 27 is any Injury or any St. Thomas More Nursing Home 4922 LaSalle Road Hyattsville, MD 20718 of Disposition (Neme of Date 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5型Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mirector Baltimore, MD 21201 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician DropharyNGEAL CANCER

Due to (or es e consequence of):

Hypertensine Cardio Vascular Disease

Due to (or es e consequence of):

Aftero-Sclerotic Cardio vasular Disease Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24a. Wes en eutopsy performed? Were eutopsy findings eveilable prior to Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28d. Describe how injury occurred 5 Pending investigation daath. 1 TYes 2 TNo 2 Accident Director: d in by tha 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) DO51122 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Juanifez, MD, 1160 VARNUM ST. NE#008. Esmerando 31. Date filed (Month, Day, Year) State JUN 2 7 2006

Registrar

3altimore, Maryland 21215-0020

Box 68760

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1,per/ID,856,6/2//05 IT

Amend item#1,er/ID,856,6/2//05 IT

Amend it 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Andrew Orgestes Jackson, Jr. 2 Date of Death 3. Time of Death Physician 9:38 PM 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore <u> Gilchrist Center @ GBMC</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Monthe Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 264-14-2255 Yrs. 84 Director Alabama Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show trsumatic avent. The Medical Examiner must be notified at 1 ☐ Yes \$ ☐ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1513 Rolling Road 21014 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Marned ŏ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Television Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit iment of Health and Mental Hiant: If item 27 is marked ott Andrew Orestes Jackson, Sr. Mattie Miltida Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Rolling Rd., Bel Air, Maryland 21014

ace of Disposition (Name of Date Date Doc. Location City or Town, State Felicia I. Jackson / Wife or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any Injury or 4 Donation 5 Nother (Specify ntombment Mt. Zion U.M. Church 6-23-06 Bel Air, Maryland JUNE 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. The disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) EMBOLIC erebrovascular accident **Physician** days /Medical Examiner with Septicemboli ENDOCARD ITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit 20 Due to (or as a consequence of) by Physician/Medical use as the signed by the ettending I be detached for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 C Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown After this certificete has been s funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No ŏ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the SO Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer de To the Funeral Diract completely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital or 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /18/ 2006 25643 endal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HaulknermD N. Charles Street 6601 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 06 CHARLOIT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
North, Day, Year Min. Month, Day, Year 19 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 1 M 2 D **Funeral** Months mari 212-22-1412 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits State 10b. County rthan "natural", or items 23a or 28a-f show the Midical Examiner Flux be nutified at 1 Yes 2 No Baltimore Director prd. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2122 1106 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify lad Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) anto 1actor 18. Mother's Name (First, Middle, Maider) Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any linjury or other traumatic event 2008. Be rler vma and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wildwood Phur dauenter Balto, mdi 1106 nestine Wise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State -21-06 are tus S ☐ Other (Specify) 4 Donation 270 FredHILTON Fass 21. Signature of uneral Jervi e Licensi Have Backs, and. 21229 er the disease, or complications that caused the death. heart failure. List only one cause on easy, ine. Approximate Do not enter the mode of dying, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a cons Examiner Squantially his conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit an attending physician Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of prior ancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day ate has been signed by the atterpage 2 should be detached for a in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 ☐ No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2500 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 ☐ Yes of Vital the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only of Hospital: Other: 1 ☐ Yes 2 N 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 🗌 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital o Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year, 29b. Signature and title of certifie

Registrar DHMH 17 Rev 1/2001

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

AMBACHEN

31. Date filed (Month

WORETA

Megistrar's Signature

	•	1 - For State Registrar	State of Maryland		tment of I ificate of			iene og. No.200	<u> 2010</u> 0
Physici /Medi Examir	al	4a. Facility Name (If not institution, give st		4	4b. City, Town,	or Location of D	2. Date of Death Month JUNE	Day Yea	6 /1904
Funeral Director		220 22 0347	H95p174L C 7. Age (In yrs. Ia M 2□F 80	st birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birth Month Day, 2/2//1	926 M	dirthplace (State or Foreign Country) aryland
he Maryland 28a-f ehow outlied at	ector	Usual Residence of Decedent	10c. City,	Town or Loca				0g. Citizen of What	10d. Inside City Limits 1 Yes 2 No
DESILITIOTE; INITY STATES A LETS-COSO permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23a or 28s-1 ehow any Injury or other treumetic event, the Macilcal Examinar must be notified at ange.	by Funeral Director	10630 Old Court Roa	ad 2. Was Decedent Ever in U.S Armed Forces? 1 전 Yes 2 및 No If Yes, Give Year or Dates:		10f. Zip Code 21163 as Decedent of Yes, specify Cub		? (Specify Yes or No- uerto Rican, etc.)	USA	merican Indian, hite, etc.
l Z I Z I D-UUSO led within 72 hours af ygiene. her then "neturel", or it, the Medical Exerti	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give kii life. DC	nt's Usual Occu nd of work done O NOT use retire rete Fi	during most of nisher	working	Constru	·
Maryiano d 2 should be file th and Mental Hy 27 is marked oth treumetic event	To Be	17. Father's Name (First, Middle, Last) David Sullivan Jer 19a. Informant's Name/Relationship (Typ	e, Print)			Artie	Name (First, Middle, M Jane McDa r Rural Route Number,	niels City or Town, State	s, Zip Code)
Dallillole, Mi Definit. Peges 1 and 2 Department of Health a mportant: if Item 27 is any Injury or other tre		Charlene J. Cofie 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pla	ace of Disposit		ice)	Reisterst /24/2006	20c. Location - City	
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To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	ToB	examiner?	ospital: 1 patient 2 E 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 ☐ Nursin	ng Home 5 Reside	nce 6 Other (Sp	oecify)
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6 1		30. Name and address of person who con ORIANDO B. CO.	mpleted cause of death (Item NANA J RE)	23a) (Type, Pr	rint)	NONTER NONTER	WEST SHE	Spital-	CENTER) 21/33
St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 7 20	32. Registrar's Signatu	15 Go	arki				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24, JUNE 2:25 P.M 2006 CHARLES FREDERICK JUERSS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**☑**M 2□F Months Days Hours Min Yrs. Director 215-16-1726 85 6/2/1921 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f ehow the Medical Exeminer must be notified at 1 Yes 2 No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8810 WALTHER BLVD. APT. 2414 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWII or itema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE MACHINIST CROWN CORK & SEAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I ie marked CHRISTIAN JUERSS GRACE LANKFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health al Important: If Item 27 ie any injury or other trau EVELYN JUERSS/WIFE 8810 WALTHER BLVD. APT. 2414 PARKVILLE. MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 6/28/2006 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Tan't. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer Physician USTAte disease or condition resulting in death) /Medical Due (o (or as a consequence of) Examiner Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital with in 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 25, 2006 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Chales St. 31. Date filed (Month, State Registrar

			State of Marylan 29d per Dr.,G	856 86	Hiffica	06dbl	eath		3	200	6 2011
Physicia /Medica	al	1. Decedent's Name (First, Middle, Last, VONNE 4a. Eacility Name (If not institution, give	ENNEDY		4b Cih	/ Town or	Location of Dea	2. Date of I	L D	c. County of	3. Time of D
Examine Funeral Director		CLINTON NURS 5. Social Security Number 6. Security	SING & REH	AB. last birthday) Yrs.	C	C//V	If Under 24 Hr. Hours Min	171	Birth Day, Year	P. C7.	D. Birthplace (State or In Country) Shington D
natural, or items 23e or 28e-f ehow dical Exac in ar must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince	George s	y, Town or Lo		1					10d. Inside City 1 ☐ Yes 2
3a or 2	I Dire	10e. Street and Number 949 Owens Road			10f. Z	ip Code	20745		10g. C	itizen of Wha USA	
if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, Ite Medicul Exact instructural Le notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☼ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		_	edent of Hisecify Cubar	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or find Rican, etc.)	No-	Black,	American Indian, White, etc. black
and Mental Hygiene. Is marked other than "natural", or raumatic event, Ita Nadigul Evari	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	life.	kind of w DO NOT	rork done d use retired)	uring most of w	orking	16b. I		ness/Industry
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27 is m		19a. Informant's Name/Relationship (Ty Earl Kennedy/son	rpe, Print)	1				Rural Route Num Hill, M		or Town, Sta 0745	ate, Zip Code)
2 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	lace of Dispo emetery, crer	sition (Natory or	ame of other place	e)	Date	20c. l	ocation - Ci	ty or Town, State
Departmen important: any injury once.		21. Signature of Euneral Service Licens	Nade, hirector		Name a State Balti	Anat More	s of Facility Comy Boa MD 21	rd 655 201	W. B	altimo	ore Street
hysicia the bu	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	uenica otj.	Car	Dt.	enala sen	~ <i>D</i>)	Slav	U.	Onset and De
y the attending piched for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fete 4□Pregnant at time of di 9□Unknown	death 3	Ectopic Other (pregnancy specify)				23d. Date of Month	,
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is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	fospital:	ER/Outpatier	nt 3 🗆 🗆	Othe		eath <i>(Check onl</i> Home 5 🗆 Re		6 □Other	(Specify)
After t funera	Certification: 7	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М		at	28d. Describ	e how inju	ry occurred	
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in 24 ho he Fun pletely I	edical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, deati tion and/or in	vestigatio	d at the tim n, in my op	e, date and place inion, death occ	ce, and due to the time	e cause(s e, date an	s) and manner ad place, and	er as stated. I due to the cause(s)
withi To th	Σ	29b. Signature and title of certifier		020) 7		9c. License	number 5365			16, 2	Month, Day, Year) 2006
Stat	te ar	30. Name and address of person who co	32. Registrar's Signa	fte	ALL	ita.	Mos	7 7 Ccs	-		

06-04335

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Mary Therese Kelly Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1038 hrs June 21, 2006 Medical Examiner Mary Therese Kelly 4a. Facility Name (if not institution, give street and number)

Redmiles Drive 4b. City, Town, or Location of Death c. County of Death Prince George's 9. Birthplace (State or ForeignPennsylvania 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Director Sept 22. 1925 80 Country) 2XX_F 198-18-7521 1 M Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 Yes 2 X No or 28a-f show items 23a or 28a-f shoust be notified at once Laurel hours after death with the Maryland MD Prince George's Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20707 USA 7005 Redmiles Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes Specify: White Divorced If Yes. Give Year 1 Yes XX No specify: 3 XWidowed Examine ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. ant: If item 27 is marked other than "I yother traumatic event, the Medical E 21215-0036 Compl Secretary Government 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Catherine Seitzinger Thomas Lonergan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 3000 Lyndebrooke Court, Fallston, MD 21047 Colleen Protzko/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, rtant: If it crematory or other place) Burial 2 XX Cremation 3 Removal from State permit. Page
Department o
Important: I 6/23/2006 West Arundel Crem. Odenton, MD Donation 5 Other Specify: 22 Name and Address of Facility Donaldson Funeral Home, 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, MD M01103 20707 100 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure List only one cause on sach line. /Medical Hypertensive Intracerebral Hemorrhane Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last d and Physician/Medical UNPENDED AMENDED attending physician or use as the burial item#23a,27,perME,g859,9/5/06 TT P.O. Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24b. Were autopsy findings available page 2 should 24a Was an has been autopsy prior to completion of cause of performed? death? ✓ Yes 2 No this certificate 1 🗸 Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25 Was case referred to medical Be Hospital: 1 Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient DOA 1 🗸 Yes 2 No ဥ funeral 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 X Natural 1 Yes 2 No Division 5 Pending - death Fo the Funeral Director: the 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Sa (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 22, 2006 30 Name and address of person

State Registrar

Zabiullah Ali, M.D.

Assistant Medical Examiner

32 Registrar's Sign

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#10b, 10c PER FH C856, 6/30/06 WS
State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 📖 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kinchen Month Year 9:45 AM Physician JUNE 25 WILLIE 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tosp morial Dalti more me nion If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** 10M 20F 74-1778 253 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location BALTIMORE CITY 10d. Inside City Limits 10a, State 10b. County 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 Pres 2 □ No ma by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Halda ne 4700 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or iteme 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: Hack 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other then Elementary/Secondary (0-12) Balkmore Hygiene. ORTOF aer 12th JIA 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 ie marked other by Injury or other treumatic event 17. Father's Name (First, Middle, Last) HOWARD USSIR N -inchen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6496 Abel ElKndge 21075 Alexander daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) valdosta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HILL Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Fred HI LTON P, march Fineral Home Belto. md, 21229 Part I Enter be disease, or complications that caused the death. Do not enter the glode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stomach **Physician** Adenocarcinoma d 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 1 No 1 Yes 1 Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AT 2438946 -1 M.D. June 25 UE, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HINA GHAFOOR M.D., UNION MEMORIAL HOSPITAL, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Day 2006 **Physician** Maryanne Cecilia Knott 25, 4:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2100 West Joppa Road Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 19,1942 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 217-40-2147 64 Marvland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or iteme 23s or 28s-f show the Medical Exemple qual by notified at 1 Yes 2 No Director Baltimore Lutherville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 2100 West Joppa Road Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Exeminant once. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 Xidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be O'Conor Hamman Helen R. Edgar 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Isabel Knott Daughter 2100 W. Joppa Road Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 6-29-2006 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 4 Donation Other (Specify) 21. Signat 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Cell **Physician** Lung 9 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) physicien a s the burial-Box 68760. Physician/Medical as ettending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant al time of death 5 Other (specify) signed by the e P.0. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 3 Probably 4 □Unknown has been signed 2 should b 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3∏ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Natura 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide entifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0056919 Uncologist 06/26/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 Baltomore MD 2120 har 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 10:30 a. м Helen McSherry Jones Kramp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Pickersgill | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 3,1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Maryland 220-09-2369 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2√XNo Maryland Baltimore Towson Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 615 Chestnut Ave. 21204 U.S.A. death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1VXYes 2 □ No If Yes, Give WW 11 Year or Dates: WW 11 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√5√No Specify: White Completed by 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Parks Elementary/Secondary (0-12) College (1-4or 5+) Naturalist permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: If Item 27 is marked other tt any injury or other traumatic event, III.a. 2006. 4 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Jeannette Shriver John Marshall Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5602 Wildwood Lane Baltimore, Maryland 21209 Semmes Kramp (Son) 20a. Method of Disposition

Y☐Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington National Cemt. 7/19/06 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Va. 21. Signature of Funeral Service LicerSi 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part1. Enter the disease, or complica each shock, or heart failure. List only one can't Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCANdink **Physician** monutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificale be executed Due to (or as a consequence of): physicien at the buting! Division of Vital Records, P.O. Box 68760, ettending pr for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) examiner? 1 ☐ Yes 2 € No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation iours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ! Charles St. Balto Md 21204 Kile 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUN 2 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 State
Registra Amend Item #20b&c Per FH C856 Willipads of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 25 2006 Year **Physician** JOHN R. LILL 15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Oak Crest Care Center Baltimore Parkville Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 27,1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑**M 2□F 161-18-7789 90 Yrs. Canada Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f shoy if Health and Mental Hygiene. item 27 is marked other then "netural", or items 23s or 28s-1 ehov other traumstic event, the Modical Examinar towat be notified at MD Baltimore Parkville 1 ☐ Yes 2√☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 3418 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specity: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) JM Huber Chemical Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental I John W. Lill Christian Wilshart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 is m eny Injury or other traum once. 8800 Walther Blvd. Apt.3418, Parkville, MD Mary L.Lill-spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 0b. Place of Disposition (warns of cometery, crematory or other place)
Angel Hill Emetery
recrimount Cemetery Havre de Grace, M Baltimore, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-27-06 4 □ Donation 5 □ Other (Specify) Greenmount 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee EVANS CHAPEL OF MEMORIES andrae LME Fadd Road-Parkville,MD 8800 Harford 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weers TNU monio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by been signe should ba 2 100 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 2 1 No After this certification, funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M 2006

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State Registrar walth

Purkulle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Landrmu

31. Date filed (Month, Day, Year)

1000

32. Registrar's Signature

			For 1_ State	State of Ma	aryland	/ Depa	artmer	nt of H	ealth a	and M	_	giene	200	16 20	1108
			Registrar			Cei	rificat	e or L	Death		2. Date of De	Reg. No). has to to	3. Time	of Dooth
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			8100 Connecticut 5. Social Security Number 6.5		40 / je (In yrs. las	st birthdav)		vy Ch riyear		24 Hrs.	8. Date of Bir (Month, Da		ntgome 9.	ery Birthplace (State Country)	or Foreign
	Funeral Director			1□M 2∏F	96	Yrs.	Months		Hours	Min.	(Month, Da Sept 3	y, Year)	909 G	<i>Country)</i> `ermanv	
	*		029-20-8378 Usual Residence of Decedent									, .			
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	or 28	Director	10e. Street and Number	. ".	. 7		10f. Zi	Code	0015			10g. Ci	tizen of Wha	t Country?	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, and Mental Hygiene, is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Eurodiner mant be notified at	a	8100 Connecticut						20815				USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	,	. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))~		American Indian, White, etc.	
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_	5 € E €		Anna Landsberg/r	iece		21 E	liot	Stre	et Ja	amaio	a Plai	n, M	A 021	L30	
ע	the He		20a. Method of Disposition		CAZ	ce of Dispo	osition (Na	me of	20)		ate	20c. L	ocation - City	y or Town, State	
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Бантпо	그 문원 중 .		21. Signature of Funeral Service Lice Ronal of S		lootor	c ² 4	2. Name a	nd Addres	ss of Facili	Nard	655 W	Rai	ltimor	e Street	
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X D	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic _I	oregnancy	,				23d. Date of Month	f delivery Day	Year
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Division	f or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	2 Accident investigate 3 Suicide 6 Could not	be 390 Block of In	niury - At hon	ne farm st	}				281. Location (Street a	nd Number o	or Rural Route Nu	ımber.
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	24 hos Fun eteky	Medical		miner: On the basis and manner s	of examination										o(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier				25	9c. Licens	e number			29d. Da	ate signed (A	Month, Day, Year)	
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			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type.	, Print)		,		BUC	ELE	Ut.	uncl-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For First State Regis**Amend Item #20b Per FH G856** 6/29/1/19/Caff of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:45 PM aenne 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4d. County of Death Examiner ftor Kd 8. Date of Birth (Month, Bay, If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 837 Months Days Hours 1 M 2 □ F Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Hartord Forest Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with or iteme 23a or 21050 1385 USF Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Yes, Give ear or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel". 15. Decedent's Education 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny liqury or other traumatic event 2008. Be 2 aer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jarretsu Duve rorest Baltimore. Db. Place of Disposition (Name or Hammeter cremater or other clace) the manual of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the clace dense of the class of the cla 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 30/06 tallston mu 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chopel-Beldir 3 New Port Dr. Forest MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Sisease of tigury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner anding physiclen and use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 Yes 2 ∏ No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 No or Attending Physicien: funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu death. investigation 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title-of certifier 20649 ce m 0 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

John W. Bowie

JUN 2 7 2006

31. Date filed (Month, Day, Year)

MARNNER

32/Registrar's Signature

6701 N. Chaires St. # 4902 Towson, mn

			For Stete Registrer	State of Marylar		artment of H rtificate of			ene 2006	20110
	Physicia /Medic		Decedent's Name (First, Middle, Las ALPHA OMEGA	MAXWELL				June 2	5 ^{Day} 2006 ^{Year}	3. Time of Death 7:25 AM
	Examin		4a. Facility Name (If not institution, give Perring Park				r Location of Death	1	4c. County of Deat Balt	imore
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9x 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt Co	hplace (State or Foreign Onio
	arylend ehow	7	Usual Residence of Decedent 10a. State 10b. County MD	•	ity, Town or Lo	Decation Balti	more			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the M a or 28e-f be notiffs	Directo	10e. Street and Number 1801 Wentwort	h Road		10f. Zip Code 212	234	10	g. Citizen of What Co USA	untry?
336	be filed within 72 hours after deeth with the Marylend tal Hygiene id other than "natural", or items 23a or 28e-f ehow event, I're Medical Examirar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ ▼ivorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White W Specify:	
21215-0036	C 1 (2)	Completed	15. Decedent's Ec (Specify only highest gra		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire Nurse	pation during most of wor d)	king	6b. Kind of Business/ Hospi	
Maryland 2	should be filed withing Mental Hygiene. marked other than matic event, tre M	To Be Co	17. Father's Name (First, Middle, Last) John Peters					ne (First, Middle, Ma Ca Larri		
	is 1 and 2 should of Health and Men item 27 is marks other treumatic		19a. Informant's Name/Relationship (1) Ralph Maxwell-		19b. Maili 130	ng Address (Street E.Clear	and Number or Ru CVieW Di	ral Route Number, cive-Shre	City or Town, State, 2 EWSbury, PA	^{Zip Code)} 17361
altimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State D	cometery cre ulaney moria	osition (Name of matory or ether play Valle Lardei	1S 16-0	27-06 T	oc. Location - City or imonium,	Maryland
Balt	permit. Page Depertment of Importent: if any injury or		21. Signature of Funeral Service Licen	ne taster	2	2. Name and Address 2325 You Timonium	ss of Facility	DAGDERT	ALTERNA EMATION	TIVES CENTER
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea	ith. Do not en	ter the mode or dyn	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	ulen !	bie Feigles	rt		
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	seles					
38760,	icate be executed physician and s the burial-transit	edical Ex	L Continue in social, case	Due to (or as a conse	quence or):	fun				
Division of Vital Records, P.O. Box 6	ath certif ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	□Ectopic pregnanc	y		23d. Date of deli Month	ivery Day Year
rds, P.	quires that the de n signed by the e uld be detached f	Ď	Part II. Other significant conditions of		sulting in the u	inderlying cause giv	ven in Part I.		acco use contribute to	the cause of death?
Reco	The law requirente has been sipage 2 should I	Completed						24a. Was an autopsy performe	ed? death?	topsy findings available completion of cause of
Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		Ott	or /	ath (Check only one,		
on of	o the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate hat ompletely filled in by the funeral director. page	ıtlon; To	1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	4 Girsing F	28d. Describe how	ce 6 Other (Spec	cify)
Divis	_ ~	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
7	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (29a. Certifier (Check only one) Certifying Ph	ysicien: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the to evestigation, in my o	me, date and place opinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	_	204.13	29c. Licens		296	d. Date signed (Monti	
6	A		30. Name and address of person who	completed cause of death (Ite	(N)) em 23a) (Type,	Print)	31464	2.0	2014	MID 2:2 C:
	Sta	to	31. Date filed (Month, Day, Year)	A HO HMI MD	AZIA	ENFAW	me 12	5001,1	DUVINNY	10111 21201
	Regist		JUN 2 7 200	6 Stephen &	- Filling					

		-	For State Registrar	State of M	faryland		artment o			nd Me		giene Reg. Not	11116	20111
*	Physicia		1. Decedent's Name (First, Middle,		-					2	2. Date of Dea Month JUN	Day	200c ^{Year}	3. Time of Death
	/Medic	al .	KAROL	INA MOTRON			4b. City, To	wn or!	ocation of	f Death	JUN	21	2006 County of Deat	2:30 A M
	Examin	er	NATIONAL NAVAL				7.	THES		Dodin		101	•	GOMERY
-5	Funeral Director		578-42-5118	.Sex 7. A 1 □ M 2 K F	ge (In yrs. Ia	a <i>st birthday)</i> Yrs.	If Under 1 Months E	Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da Dec. 5	h y, Year) , 19:	Co	hplace (State or Foreign untry) rmany
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgo	mery	Bet	hesda								1 □ Yes 2¶ No
	or 28	Director	10e. Street and Number				10f. Zip Co						zen of What Co	
	s 23s	Funeral	10008 Broad Str	eet 12. Was Deceder	nt Ever in U.S	S 13.	208 Was Deceder		panic Orig	in? (Spec	ifv Yes or No		ted Star 14. Race - Ame	
36	d within 72 hours after death with the Maryland jiene rithen "natural", or items 23s or 28s-f show ite Medical Examination must be multified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces	? I No		If Yes, specify	Cuban	Specify:	, Puerto R	ican, etc.)		Black, White Specify: Wh	e, etc. nite
2-00	72 hou	eted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual (Occupa done du	tion uring most	of working	2	16b. Kii	nd of Business/	Industry
121	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	ing Cl	retired)				Not	t Availa	ahle
d 2	Hyg Tr		17. Father's Name (First, Middle, La	ist)	Į.	DIII	Ing or		18. Mother	r's Name (First, Middle,			CLD II.
lan	o g p o	To Be	Not Av	ailable					Not		Ava	ailal	ole	
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship			1831	0 Mont	gom	ery V	illa	ge Avei	nue,	r Town, State, 2 Suite	Zip Code) 400
	1 and 1 Health sm 27 sther tr		Richard F. Stef	anelli/Att	20b. P	lace of Dispo	gomery sition (Name	of		Da	te		879 cation - City or	Town, State
E O	Pages nent of h ant: If its ury or of		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Mon	tgomer	matory or othe Y Lum, Ir		"	June 200		Bet	thesda.	Maryland
Baltimore,	permit. Page Department of Important: if sny injury or once.		21. Signatu eral Service Li	Berry		2	2. Name and	Address	s of Facility	Robe	ert A. Inc.	Pum	phrev F	uneral Home/ onsin Avenue
96	**************************************		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caus	ed the death	n. Do not en	ter the mode of	of dying	, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ aCO	RONARY	ARTE	RY DIS	EASI	Ξ					Onset and Death
	/Medical Examiner		resulting in dealth)	Due to (or a	as a consequ	uence of):								
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	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or a		unnen of								
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687	ificate g phys as the	edic		0										-
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	Ideath 3	⊒Ectopic preg ⊒ Other (spec					4	23d. Date of del Month	ivery Day Year
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ecords,	w require been sig should b								_		1 🗀 '	Yes 25	XNo 3□Pr	obably 4 Unknown
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	• • • • • • • • • • • • • • • • • • • •	50/0		Othe			(Check only o		2 🗆 🗆	
of		n: To	1 ☐ Yes 2 🔯 No 27. Manner of Death	1 V Inpa 28a. Date of In	njury	28b. Time of		. Injury Work	4 140		Bd. Describe		6 □Other (Spe y occurred	city)
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Division	al or Atta after de i Directo d in by th	Certification:	3 Suicide 6 Could no 4 Homicide determin	led 286. Place of	Injury - At ho etc. (Specif		reet, factory,	office		2	8f. Location (City or To			ural Route Number,
	To the Hospital or Attance, within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the be xeminer: On the basis and manner	of examina									
	To th within To th compl	Me	29b. Signature and title of centrel	4	5		29c.	License	number				te signed (Mont	
	0		> MM	1()	100		0	102	20177				0-21-	
1	0		30. Name and address of person w	SON CPT	MC US	SAF					AL NAVA DA MD 2		EDICAL (9-5600	CENTER
	St Regist	ate rar	31. Date filed (Month, Day, Year)	7 2005 32. R	strar's Signa	Sture	perti	,						

			For State Registrar	State of Maryla		artment of Hertificate of L			7 1 1 1 1	6 20112
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alexander Miller					2. Date of Dea June	23, 200°	3. Time of Death 11:10 P M
Ĭ	Examin		4a. Facility Name (If not institution, give s Holy Cross Hospita			4b. City, Town, or Silver	Location of Death	h	4c. County of Dec	
	Funeral Director		311-32-3219	M 2□F 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		r. Year) C	irthplace <i>(State or Foreign</i> Country) cthern Ireland
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the ? 3s or 28s-	i Director	10e. Street and Number 13818 Marianna Dri	ve		10f. Zip Code 2085	3		10g. Citizen of What C	
36	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23s or 28s-f show event, the Madical Examiner count to notified at	by Funerai	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W	nite, etc.
Maryland 21215-0036	within 72 hou ene. then "nature ne Marical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) 2	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, ance Agen	uring most of wo	rking	16b. Kind of Busines Insurane	
Ž.	m = 0 \$	To Be Co	17. Father's Name (First, Middle, Last) John Miller		_1		18. Mother's Nar	ne (First, Middle, n Lemmon	Maiden Sumame)	
, Mary	permit. Pages 1 and 2 should be Department of Heatils and Menta Importent: If Item 27 is marked eny Injury or other traumatic en <u>pnce</u> .		19a. Informant's Name/Relationship (Type Kathleen June Mill	er / Wife	13818	Marianna	Drive,	Rockvil1	r, City or Town, State, Le, Maryla	• •
altimore,	Pages 1: ment of He ent: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【3【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	cemetery, crei	sition (Name of matory or other place Crematorium		Date 25,	Bethesda,	
Balt	Departi Departi Importi eny Inj 2002		21. Signature of Funeral Service License	M0	Ro	ckville,	<u>Marylano</u>	<u>1 20850-2</u>	2805	Funeral Home/ Avenue
	Physician	25	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de- e cause on each line. Cardiomyo		er the mode of dying	, such as c <i>a</i> rdiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed when the law requires that the law requires that the law requires the law requirement of the law requirements of the l	dicai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	Artery	Disease			, , , , , , , , , , , , , , , , , , ,	
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Il Records,		Completed						24a. Was a autop perfor 1 □ Yes	sy prior to med? death?	autopsy findings available completion of cause of second No.
Vital	yslcisn: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: 1⊠Inpatient 2[☐ ER/Outpatier	nt 3□ DOA Othe	r	ath <i>(Ch</i> eck only on Iome 5 ☐ Resid	ne) ence 6 ⊡Other <i>(Sp</i>	ecify)
Division of	ng Ph Ifter th Ineral		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury Work			ow injury occurred	
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)	To the Hos within 24 h To the Fur completely	Me	29b. Signature and the of certain		mo	29c. License		2	June 23,	
6	1		30. Name a address of perso o Ronald Wheeler M.D	pleted cause of death (It	em 23a) (Type,		o. Marvi	land 2077	74	
	Sta Registi		31. Date filed (Month, Day, Year)	20. Domittado Cia						

		State Registrar		Cer	tificate o	f Death	2. Date of Dea	Reg. No.	2006	3. Time of Death
hysicia		Decedent's Name (First, Middle, Last)	Elmer D. McC	Cov			Month June	Day 22	2006	4:55 A.
/Medic xamin		4a. Facility Name (If not institution, give s Stella Maris Ho	street and number)			, or Location of Dea Onium		4c. (County of Death Baltimor	
neral ector		217 40 2339	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Yes Months Day			2,19	9. Birthp Cour Mary	olace (State or Fore otry) y Land
T T	25	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		y, Town or Lo Baltimo					1	0d. Inside City Lin
De notifie	Directo	10e. Street and Number 328 W. Arden Ro		- CINC	10f. Zip Code	1225			ten of What Cour	
other then nature, or here ass or assistant event, the Medical Executer trust be notified at	Completed by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No Viel If Yes, Give Year or Dates:	t		f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
other then natural, or he rent, the Medical Exercities	npleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L		cupation ne during most of wo ired)	orking		nd of Business/In	
4	Co	12th 17. Father's Name (First, Middle, Last)		Pol	iceman	19 Mother's Na	ıme (First, Middle,		timore C	ity
	To Be	Elmer	Leo McCoy			Mar	garet Ke	l1er		
other traumatic		19a. Informant's Name/Relationship (Ty) Judy S. McCoy / V	/ife	328 W	. Arden		altimore	, Mar	ryland 2	1225
ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		sition (Name of natory or other p lge Mem.	nace) Park 6/2	Date 6/2006		eation - City or To	
any Injury or of once.		21. Signature of Funeral Service License		22	. Name and Add		Gonce Fur			e, P.A. land 212
nysicien and dical niner he burial-transit niner	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	uence of):	CIDENT					Onset and Death
by the ettending physicached for use as the t	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d	death 3	Ectopic pregnal Other (specify)			2:	3d. Date of delive	ory Day Year
2 8 1	d by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	iderlying cause	given in Part I.		bacco us		ne cause of death
cate nas been signe , page 2 should be (Completed						24a. Was a autop perfor		24b. Were auto prior to coi death? 1 \(\subseteq \text{Yes} \)	psy findings avail npletion of cause 2 No
rector, pa	Be c	25. Was case referred to medical examiner?	lospital:	FD10		Ther	ath Check only or		-	HOODTO
: Atter this e funeral di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	4 🗀 Nursing	Home 5 ☐ Resid 28d. Describe h) HOSPIC
10 the Funeral Director: Atter completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specifi	ome, farm, str	eet, factory, offic	ce ·	28f. Location (S City or Tow		l Number or Rura	l Route Number.
ne Funer oletely fills	Medical (29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and plac y opinion, death occ	e, and due to the durred at the time, d	ause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
E CO	M	29b. Signature and title of certifier				43725	_	29d. Date	signed (Month,	Day, Year)
			mpleted cause of death (Item	22a) (Tues	D-1-4)					

DHMH 17 Rev 1/2001

4:55 a.m.

JUNE 22, 2006

ELMER MCCOY

06-04371

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Larry McLaurin 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 20, 2006 Larry L. McLaurin 1247 hrs Medical Examiner 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) n/a Baltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Foreign Months Days Hours 217-84-8659 Director Country) 05-25-1959 1X M 2 F 47 Yrs Usual Residence of Decedent 10d Inside City Limits Au A 10a. State 10b. County 10c. City. Town or Location n/a Baltimore 1 X Yes 2 No MD28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygore.
anti: If item 27 is marked other than "natural", or items 23a or 28a-f sho ro other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 1107 Wheeler Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married African-Specify: American Yes 1 Yes 2 X No specify If Yes, Give Year 4 XDivorced 3 Widowed ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Car Dealership 12th Auto Detailer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John McLaurin Christine McLaurin Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Danara McLaurin-Robinson Carver Drive, Jackonsville, NC28540 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Cedar Hill Ceme. 1X Burial 2 Cremation 3 Removal from State 6/27/06 Glen Burnie, MD Department or Important: I Donation 5 Other Specify 22. Name and Address of Facility $\overline{W}y11eF/\overline{H}P.A.$ of 21. Signature of Funeral Service Lic. Balto. 9200 Liberty Rd., Randallstown, MD 21133 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I Enter the disease of Physician Between Onset and failure. List only one caus /Medical Death Cocaine intoxication with omlications Immediate Cause (Final distase xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, of any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed and Physician/Medical AMENDED item#23a,27,28a-f,perME,g857,7/13/06 TT attending physician of the burial -X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director. 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Yes 2 No 3 Probably 4 🗸 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? Yes 2 V No 26 Place of Death (Check only one 25 Was case referred to medica Be Other₄ examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 Other DOA ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 No 5 Pending Fnd 6/16/2006 Fnd 10:00 pm Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1107 Wheeler Ave.
Baltimore, MD 28e, Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) Found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 23, 2006 O.C.M.E. ronus 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month JUN 2 State 2006 Registra

ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink Amend 1 Fem / Department of Health and Mental Hygiene vt

	1- For State Certificate		Reg. No. 2006 201
Physician/ dical Examiner	1. Decedent's Name (First, Middle, Last) Micheal B. Nevin Michael B.	Nevin Ju	late of Death fonth Day Year 0700 hrs
	4a. Facility Name (if not institution, give street and number) 1775 Rockville Pike	4b. City, Town, or Location of Death Rockville	4c. County of Death Montgomery
Funeral Director	324-84-3281 A	Months Days Hours Min.	Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Nov 1 ,1956 Country Montana
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	CO E1 Paso Colorado 10e. Street and Number Northwind 6710 N. Withwind Dr.	10f. Zip Code 80918	10g. Citizen of What Country? United States
er death w , or items r must be Funer	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical Yes 2X No specify	
od within 72 hours aft yegiene other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation (Give kind of work g most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry
should be filed within 72 and Mental Hygiene 77 is marked other than 'natic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) James Robert Nevin	ospace Engineer 18 Mother's Name (Fin Patricia	Engineer st, Middle, Maiden Surname) Devine
e, MD 2 121 and 2 should be fi and 2 should be fi item 27 is marked traumatic event,	19a Chrome S Name/Relationship (Type, Print) 19b. Ma Gail Nevin / Wife 67:	0 N. Withwind Dr.,	Route Number, City or Town, State, ZCOpde) Colorado Springs, CA 80918
Definitione, in Department Pages I and 2 Department of Health Important: If item injury or other trans	1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other Specify:	position (Name of cemetery, other place) aw Funeral Home 6–8	CO
		5130 Wisconsin Ave,N	.W. Washington DC 20016
Physician /Medical Examiner	fallure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Acute Hemorrhagic Pance or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
red Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expets resulting in death.) Last one of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions, if any, leading to immediate cause. Due to (or as a consequence of):		
rou, icate be executed physician and the burial - transit	events resulting in death) Last d X UNPENDED AMENDED item#23a,27,per	ME, G856,6/28/06 TT	
J. BOX 03 / 0U, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d Date of delivery Month Day Year
gned by the e detache	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
DIVISION Of VITAI RECORDS, P.O. tall of Attending Physician: The law requires that the staffer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact entification: To Be Completed by P			24a. Was an autopsy performed? 1 ✓ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
Vital R ysician: 1 ysician: 1 this certific director, p	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26.Place of Death (Check only nent 3 DOA Other Nursing Ho	
DIVISION OF ital or Attending Phurs after death ral Director: After tilled in by the funeral certification: T	27. Manner of Death 1	1 Yes 2 No	Describe how injury occurred
	3 Suicide 6 Could not be determined (Specify)		. Location (Street and Number or Rural Route Number, City or Town, State)
To the Ho within 24 To the Fu completely	29a Certifier 1 Certifying Physician: To the best of my knowledge, death o one) 2 Medical Examiner: On the basis of examination and/or inves and manner stated. 29b. Signature and title of certifier	courred at the time, date and place, and due ligation, in my opinion, death occurred at the 29c. License number	e time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year)
	30. Name and ad ress of person who completed cause of death (Item 23a)	O.C.M.E.	June 4, 2006
	Margarita Korell MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 212	201
State Registra	1111 0 × 2000 6	grante.	

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		lental Hy	/giene Reg. No	2006	20116
			1. Decedent's Name (First, Middle, Last)				2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medic		James Ed	ward Nabl	O					2006	5:35 P M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c.	County of Deeth	
			Forest Hill Heal	th & Rehal	oilitation	Forest	Hill		I	Harford	
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birthp	lace (State or Foreign stry)
н	Director		221-12-5558	JM ZLIF	92 Yrs.			June 8	, 191	4 Dela	aware
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits
	laryla sho	ō	Maryland Harford		Forest Hi	11					1 ☐ Yes 2X No
	the N	Directo	10e. Street and Number	***************************************	TOTOSC III	10f. Zip Code			10a Cit	tizen of What Cour	atry?
	a or										, .
	eath	era	109 Forest Valley	Drive 12. Was Decedent I	Ever in U.S. 13.	21050 Was Decedent of H	lispanic Origin? (Sp	ecify Yes or N	US.	A 14. Race - Americ	an Indian,
10	fler of their drawn free free free free free free free fre	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White,	
38	ours after death with the Marylan rel', or items 23a or 28a-f show Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 💥 No	Specify:			Specify: Whit	te
21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show offeal Examiner must be notified at	Completed	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup	ation	ring.	16b. K	ind of Business/Inc	dustry
215	_ 2	ple	(Specify only highest grad	College (1-4or 5	i+) (GIV	e kind of work done o DO NOT use retired	during most of work d)	ang			
21	giene.	P.O.	10		Fam	er			A	gricultu	ce
	be filed tal Hygie d other l	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maiden	Sumame)	
Ja		2	C. Edward Nabb				Sarah A.	. Savin			
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mai	ing Address (Street	and Number or Run	al Route Numi	ber, City o	or Town, State, Zip	Code)
	1 and Health lem 27 sther tr		Harold S. Daniels	/ Stepson		Dublin Rd					034
ore	0 0		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 🔀	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place		Date	20c. L	ocation - City or To	wn, State
Ē	Pages ment of ent; if it ury or o		*4 □ Donation 5 □ Other (Specify			l Cemetery			Town	nsend, Do	laware
Baltimore,	permit. Pag Department Importent; I any injury o		21. Signature i Fune al Service Licens		N ²	2. Name and Addre	ss of Facility Ineral Hon	ne. P.A	_	(%)	
Ш	20599		rounces 1 h	mast	[1	.31/ Cokes	bury ka.,	, Abing	aon,	Maryland	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lication that caused cause on each li	I the death. Do not earle.	nter the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	une	dans						Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	Examiner	L	Sequentially list conditions,	b							
	be ii	Examine	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	be executed sician and burial-transit	хаш	that initiated events resulting in death) Last	c	a consequence of):						
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87	ate ohy:	Physician/Medical		d							
9 X	attending parties for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of delive	arv
Вох	atten for u	clan	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1			Month	Day Year
P.O.	that the de led by the a detached i	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	res that igned b	Y P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?
Records,	uires n sigr	d by	dementes					1 🗆	Yes 2	□No 3□Prob	ably 4 Unknown
200	w requir been si should	Completed						24a. Wa	s an	24b. Were auto	psy findings available
Re	has ge 2	d L						auto	ormed?	prior to con death?	mpletion of cause of
a		e Co	25. Was case referred to medical				OC Plans of Pass	1 Yes	2 No	1 Yes	2 No
of Vital	Physicien: this certificated director,	m	examiner?	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Deat			6 ☐Other (Specify	w)
	Phys r this aral di	To To	27. Manner of Death	28a. Date of Inju	ry 28b. Time			28d. Describe			//
OU	th. : After funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injury		k? Yes 2 □ No				
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be	286. Place of Inj	ury - At home, farm, s	treet, factory, office				nd Number or Rura	il Route Number,
D	To the Hospitel or A within 24 hours after To the Funerel Direction place of the formula of the	ert	4 Homicide	building, et	с. (Ѕреспу)			City of 10	own, State	9)	
	To the Hospitel within 24 hours a To the Funerel I completely filled				of my knowledge, dea						
	ne Ho ne Fu	edical	(Check only 2 Medical Examone)	and manner sta	f examination and/or i ated.	nvestigation, in my o	pinion, death occur	red at the time	, date and	d place, and due to	the cause(s)
	within To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
	4		1 Down 5	2		0	32255		1-	15 22 26	6 7
			30. Name and address of person who	completed cause of d	leath (Item 23a) (Type					,	
	2		DAVAD 5-	Some		moc Phy-	1 Re	1011)	100		
	sh Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						
	Regist	rar	JUN 2 7 20	06 2	Je Je	1					
DH	MH 17 Rev 1/2	2001		John							
					ORIĞIN	AL					

06-04411 Anthony James	Owe	Amend Item #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #21 per Press Smith #22 per Press Smith #22 per Press Smith #22 per Press Smith #23 per Press Smith #23 per Press Smith #23 per Press Smith #24 per Press Smith #25 per Press S	tain Mack Indelible Ink	giene		
runnony damed	1	- For State Certifica	te of Death	Re	g. No. 200	6 2011
Physicia Medical Examir	ın/ ner	1. Decedent's Name (First, Middle,Last) ANTHONY JAMES OWENS-SMITH		2. Date of Death Month June 24, 2	Day Year 006	3. Time of Death 0003 hrs
		Facility Name (if not institution, give street and number) Howard County General Hospital	4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1	h(MM/DD/YYYY) 9. Birti Foreigi 16, 1986 ^{Cou}	
any	ļ	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town of	r Location			10d. Inside City Limits
ž .	_	Maryland Howard Savag				1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	إذة	10e. Street and Number	10f. Zip Code		g. Citizen of What Coun	try?
ith the		8875 Howard Hills Drive 11. Marital Status 12. Was Decedent Ever in U.S.	20763 13. Was Decedent of Hispanic Origin? (Spe		U.S.A.	can Indian, Black,
Jeath w	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto R		White, etc.	
s after or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2XX No specify: Decedent's Usual Occupation (Give kind of wo	ork dono	Specify: B 16b. Kind of Business/Ir	lack
2 hours	eted		uring most of working life. DO NOT use retire		TOD. KIND OF BUSINESS/II	idusiiy
036 tithin 7 ene rr than Aedica	E C	Grade 11	Student		Student	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	ادہ	17. Father's Name (First, Middle, Last)	18.Mother's Name (Maiden Surname)	
212 ould be Menta marke ic eveni	m	Antonio Owens-Smith 19a. Informant's Name/Relationship (Type, Print) 19b	Mailing Address (Street and Number or Ru		ber, City or Town, State,	Zip Code)
MD id 2 shoulth and m 27 is aumati			875 Howard Hills Driv	re Sava	age, Maryla:	
Ore, ses lan of Hea frite ther tr		1 Burial 2 X Cremation 3 Removal from State cremato	ry or other place)		-	
altimore, mit. Pages 1 a partment of He pportant: If ite		4 Donation 5 Other Specify: West A 21. Signature of Funeral Service Licensee per Dvr	Arundel Crematory 6/3 22 Name and Address of Facility Donaldson Funeral E			Maryland
Ba perm Depa Imp	_	Gregory S Karoman / M00770	313 Talbott Avenue	Laure:	l, Maryland	20707
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds)	enter the mode of dying, such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
execute	ca	UNPENDED AMENDED	· · · · · · · · · · · · · · · · · · ·			
760, cate be physical	cian/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician	past 12 months? 1 Live birth 4 Pregnant at time of death 5 Unknown 9 Unknown		icy	Month D)ay Year
s, P.O. I	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		bacco use contribute to	
tal Records, cian: The law require certificate has been si	Completed			24a. Was a autop perfor	sy prior to c med? death?	topsy findings available completion of cause of
n: The rifficate for, page		25. Was case referred to medical	26 Place of Death (Check o		2 No 1 Ye	\$ 2 NO
of Vita ing Physicia After this ce uneral direc	To Be	examiner? 1 Ves 2 No Hospital 1 Inpatient 2 VER/OL			Residence 6 Other	
n of oding Ph. h. : After t		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28a. Date of Injury Under the properties of the pending	' ' ' ' lo	Subject sho	now injury occurred t	
Division of Vital ospital or Attending Physician: hours after death. neral Director: After this certified in by the funeral director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be		or Town S	Street and Number or Ru state) April Way, Columb	
D) the Hospital hin 24 hours the Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and	due to the caus	se(s) and manner as start	ted.
To the Howithin 24 P	Medical	one) 2 Medical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occurred at 29c. License number	the time, date	and place, and due to th	
	2	29b Signature and title of certifier A A A A A A A A A A A A A A A A A A A	O.C.M.E.		June 24, 2006	, 2007, 1001/
		30. Name and address of person who completed cause of death (Item 23a)			-	
وا			Penn Street, Baltimore, MD 21201			
Regis	tate	31. Date filed (Month Day, Year) 006 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1,perME,0856,6/2/00 TD epartment of Health and Mental Hygiene

Amend item#1,perME,0856,6/2/00 TD Contillator of Dooth 1 - State Registrar Certificate of Death Reg. No. Phyllis Patricia Clere Quendi ik 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2000 uwendi TUNK /Medical 4b. City, Town, or Location of Death 4c. County of Death lity Name (If not institution, give street and number) **Examiner** Glew
If Under 1 Year ned Burnie Ash 8. Date of Birth (Month, Day, Y Mar. 23/ If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Hours 1 ☐ M 2 🔀 F 555-46-0022 74 Yrs. T932 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r 28e-f show rotified at tyr Yes 2 ☐ No Florida Brevard Palm Bay Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Examiner must be 795 Haftez Street NE 32907 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11 Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 0 Maryland 21215-0036 1 Tyes 2 No Specify: White Specify: ģ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygiel
Importent: If item 27 is marked other It
any injury or other treumatic event, Ite
once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mc Clelland Estill Clere Ruby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 795 Haftez Street NE Bonnie Thom Daughter Palm Bay, Florida Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 6/23/2006 Catonsville, Maryland Metro Crematory * 4 □ Donation \$ □ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signatur of Funeral Service Licensee 3631 Falls Road, Baltimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Trteriose Physician levotro /Medical ue to (or as a consequence of) abetes Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transil and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Minknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 200 of Vital Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PR/Outpatient 3 □ DOA 1 Yes 2 No After this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Division 5 Pending 1 TYes 2 No death. investigation the hours after deat unerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 6 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 America Ct. JONES, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUN 2 Registra

			For 1_ State	State of Ma		d / Depa	artment o	f Health a		ntal Hyg	(2006	20	1119
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e o	l and lealth im 27 her t		Jacqueline Joyce 20a. Method of Disposition	Osborne/wi			sition (Name o		Date			tion - City or		20900
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		For State Registrar		State of Ma	-	epartmer C <i>ertifica</i> :			Mental Hy	/giene Reg. No.	200	6 20120
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and w		Usual Residence of Do	ob. County		10c. City, Town	or Location						10d. Inside City Limits
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Dallimore, Permit. Pages 1 s Department of He mportent: If Item iny injury or oth				lemoval from State	20b. Place of I cemetery Meadowr				Date 7/2006		cation - City o	
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			State of Maryland	-			ental Hyg	giene 2006	5 20121
			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	rtificate of Deati		2. Date of Dea	Reg. No.	3. Time of Death
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	/Medic Examin		4aa Facility Name (If not institution, give street and number)	1	4b. City, Town, or Location	n of Death	00,00	4c. County of Dea	
			BAITINGLE WAShington Medical Ce	ner	GIENBURN	SIE			PRUNDEL
	Funeral Director		5. Social Security Number 6. Saft 7. Age (In yrs. Ia 219 38 2959 1. 2□ F 66	ast birthday) Yrs.	Months Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day April 2	^{9. Bi} 21, 1940 Ma	thplace (State or Foreign ountry) ryland
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	the N 28a-1	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	h with 23e or	al DI	8015 Fair Breeze Drive		21144			U.S.	
	tems	uner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Spectan, Puerto F	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
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89 x	artifica ing ph e as th	Physician/Medical	IF FEMALE:						
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	O_i	18	30 Name and advicess of person who completed across of death (Item	23а) (Туре,	Print)	1	^		2 mg/612
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		•	For State	_	epartment of Health and Me Certificate of Death		4000 7017
			Ragistrar 1. Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death
н	Physicia		MARY FAIL	Quala	-4	Month D	Day Year 6:45PM
,	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Death
			MARINER - 5. 5. Social Security Number 6. Se	7. Age (In yrs. last birthd	CA-TONSVIII	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 28 F 79 Yrs	Months Days Hours Min.	(Month, Day, Yea	Country) MARYLAND
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	or Location		10d. Inside City Limits
	Manyia -f aho	tor	MD BALTIMO	11	ETHORFE		1 ☐ Yes 2 ☑ No
	s i end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exeminations in the rotilised at	Funeral Director	10e. Street and Number	^ -	10f. Zip Code	10g. (Ditizen of What Country?
	s 23a	rail	4708 RUBY	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spec	city Ves or No-	14. Race - American Indian,
(0	r Item	Fune	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto P	Rican, etc.)	Black, White, etc.
21215-0036	within 72 hours after ane. "natural", or Ite he Medical Exemina	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: WhITE
15-(in 72 h	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (C	ecedent's Usual Occupation Give kind of work done during most of workin fe. DO NOT use retired)	16b.	Kind of Business/Industry
212	d with giane.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	ZEDIT MANAGEN	e 2	EWELRY
	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	en Sumame)
Maryland	2 should be and Mental is marked o	우	HENRY CLAY L 19a. Informant's Name/Relationship (T	DUE 19h M	Mailing Address (Street and Number or Rural	PETER	Super Town State Zin Code)
Ma	nd 2 silith an 27 is r		A - 114 -	ale, SON 470	ORRUBY AVE HALET	DODEMI	21227
re,	is 1 end of Health Item 27 other tr		20a. Method of Disposition	20b. Place of D	isposition (Name of Da crematory or other place)		Location - City or Town, State
im	Pege ment c ant: If ury or		1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	BEIAIR A	EMDRIAL PARK 6-2	3-06 BE	LAIR, MD.
Baltimore	permit. Peges 'Department of Himportant: If Ite eny Injury or of once.		21. Signature of Fundial Service Licens	**	22. Name and Address of Facility Daugherty Family Funeral Horr	ne And Cremation	Center, P.A.
			23a. Part 1. Enter the disease, or somp	ications that caused the death. Do not	2601 Mountain Road - t enter the mode of dying, such as cardiac or	Pasadena, MD. 2	Approximate
	Physician		Immediate Cause (Final	ne caus é en eadrine . NETASTATI		En	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequence of)			7 701,112
Н	Examiner	2	Sequentially list conditions,	b. Due to (or as a consequence of)		-	
	uted I Insit	Examiner	if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury				
o,	ate be executed only sicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of)	:		
8760	death certificate be executed e attending physicien and id for use as the burial-transii	dical		d		<u>.</u>	
9	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death e atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	that the di ed by the detached	hys	9 Unknown	9□ Unknown		T	
Ś	8 G 6	ρ	Part II. Other significant conditions co	ntributing to death but not resulting in the	he underlying cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
COL	w require been si should t	Completed	7 .3			24a. Was an	24b. Were autopsy findings available
Re	The law ete hes b page 2 si	mo.				autopsy performed?	prior to completion of cause of death?
ital		BeC	25. Was case referred to medical examiner?		26. Place of Death	1	
× ×	S S	일	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		ne 5 Residence	6 ☐Other (Specify)
Division of Vital Record	aling After fune		27. Manner of Death Natural 5 Pending	28a. Date of Injury 28b. Tim (Month, Day Year) Inju		8d. Describe how in	jury occurred
/isi	dea dea tor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Naminide determined	28e. Place of Injury - At home, farm			and Number or Rural Route Number,
á	p the p	Cert	4 Homicide	building, etc. (Specify)		City or Town, Sta	ite)
	To the Hospital (within 24 hours at To the Funeral Dominal Completely filled in	Medical	29a. Certifier (Check only one) Check only 2 Medical Exem	sician: To the best of my knowledge, oner: On the basis of examination and/oner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	nd due to the cause od at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
C	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			1 there	2 ms	0006176	5 50	DWE 22ND 2006
,	11		30. Name and address of person who o			W. 10 53	220
	Sta	ate.	3350 WILLES	32. Pigistrar's Signature	Joseph Spark	WB U	ccy
8	Regist		31. Date filed (Month, Pay, Year) 2	1006 Alexan St	Spark		

	·	1 = For State Registrar	State of Ma	aryland		artmen tificate			and M		Reg. No.	2006	5 20	123
Physici /Medic	al	Decedent's Name (First, Middle, Last) Ferilia Name (Heat in this in the interest in the interest in the inte	Rudolph	Rasp	et	4h Cib.	Tour or	Lagation	of Doorb	2. Date of De Month June	19,	2006	5:35	of Death
Examin Funeral	er	4a. Facility Name (If not institution, give s Suburban Hospi 5. Social Security Number 6. Social	cal 7. Ag	e (In yrs. la	ast birthday)		Beth	esda If Under		8. Date of Bi		Mont g	omery	
Director		169-05-6718 Usual Residence of Decedent 10a. State 10b. County	M 2□ F	96	Yrs.		Days	Hours	WIII).	JAN 13	3, 19		nnsylva 10d. Inside	
within 72 nouts after beath with the Maryland one. Then "natural", or lisme 23s or 28s-f show ne Modical Examiner : aust be nutified at	Director	MD Montgo				10f. Zip	Code	ingto			10g. Citiz	en of What C		s 2 No
"natural", or itsme 23a or 28a-f show colcel Exeminer i wat be nutified at	by Funeral Director	11219 Dewey Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Deced f Yes, spec	lent of Hi offy Cuba			ecity Yes or No Rican, etc.)		Black, Wh Specify:	nerican Indian, ite, etc. White	
al Hygiene. I other than "natural", or itsme vent, the Modical Examiner ro	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+)	life. I	lent's Usua kind of wor DO NOT us TUMEN	rk done d se retired	<i>luring</i> mosi)	t of worki	ng		d of Busines	s/Industry	Survey
ad other	To Be C	17. Father's Name (First, Middle, Last) Martin	Raspet					Ka	thry		, Maiden : aharn	Sumame) ar		
nent of Health and Mer ant: if item 27 is marke ary or other treumatic		Ronald A. Raspet, 20a. Method of Disposition 1 Burial 2 Coremation 3 B 4 Donation 5 Other (Specify)	son	ce		Dewersition (Name	ey Co	ourt	Ken	Sin tor	20c. Loc	2089 ation - City o	5 r Town, State	
Department of important: If i any injury or once.		21. Signature of Funeral Service License	George		bb ²²	. Name an	d Addres	s of Facilit	y Cre	mation d Balı	Soci	<u>ltimor</u> ety of e, MD	MD, Ir 21228	nc.
wx with the attending physicien and with the page 2 should be detached for use as the burial-transit and a large.	dical Examiner	23a. Part1. Enter the disease, or comblishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each li Seps: Due to (or as	is a conseque ary T	ence of): ract] er oe of):			g, such as	cardiac	respiratory a	irresi,		Approxim Interval Bi Onset and	etween
led by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pro					2	3d. Date of de Month	elivery Day	Year
been signed by should be deta	۵	Part II. Other significant conditions cor	tributing to death b	ut not resul	lting in the u	nderlying ca	ause give	en in Part I.			tobacco us	-	to the cause of	
ete has page 2	Completed									1 ☐ Yes	psy ormed? 2 No	24b. Were a prior to death?		s available cause of
Jeath. tor: After this certificel the funeral director, p	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	ER/Outpatien 28b. Time of Injury	м 2	8c. Injury Work	er: 4 □ Nu	rsing Hor	n (Check only me 5 ☐ Res 28d. Describe	idence 6 how injury	occurred		
within 24 hours after death. To the Funerel Director: After completely filled in by the fune		4 Homicide determined	28e. Place of Inj building, et sician: To the best	of my know	viedne death	occurred	at the turn	ne, date an	d place a	City or To	wn, State)	and manner a	Rural Route Nu	
within 24 i To the Fu completel	Medical	(Check only one) 2 Medical Examinates 29b. Signature and title of certifier	and manner sta	examinati	on and/or in	290		number	th occurr	ed at the time,	29d. Date	signed (Mor	oth, Day, Year)	(s)
8	ite	30. Name and address of person who concern the second seco	mpleted cause of d Old Geor	getov	vn Roa	Print)		iesda.	, MD	20814		ne 19,	2006	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 20124

			For State Registrar	State of Mar		ertificate of			Reg. No.	00	40) for "T
			Decedent's Name (First, Middle, Last)			Timodio or	Doda	2. Date of De	ath	_	3. Time of I	Death
	Physicia		Doris Elaine	Robinson				Month	Day	Year	1150	AM
ě	/Medic Examin		Doris Elaine 4a. Facility Name (If not institution, give s		1 .	4b. City, Town,	or Location of Death	Jane	4c. County		1150	
	LAGIIIII	eı .	Sinai Hospital	of Bal	tindo	Bolte	more C	ily.	n/a	ı		
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday	If Under 1 Year	. If Under 24 Hrs.	8. Date of Bir	th	9 Birtho	lace (State or	Foreign
	Director		218-26-3140	M 20∑F	80 Yrs.	Months Days	Hours Min.	July 1	8,1925	Mis	souri	
	D.		Usuaf Residence of Decedent		0- O'- T						Ord foreign City	. Limite
	arylar show	_	10a. State 10b. County	'	IOc. City, Town or I					11	0d. fnside City 1 🔲 Yes	
	88-1	Director	Maryland Baltimore	2	Hunt			T				- X
	vith ti	급	10e. Street and Number			10f. Zip Code	1000		10g. Citizen of		try?	
	s 23e	Funeral	1700 Worthington I	Heights Pa 12. Was Decedent Ev			1030	nooity Voc or No		JSA e - Americ	an Indian	
	itam itam	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		ff Yes, specify Cui	Hispanic Origin? (Sp ban, Mexican, Puert	o Rican, etc.)	Bfa	ck, White,		
36	rs aft	by F	3 X Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specif	w. Whit	Δ	
9	within 72 hours after deeth with the Maryland liene. rthen "natural", or Itame 23a or 28e-f ehow Ita Medical Examinar must be notified at		15. Decedent's Educ	cation	16a. Dec	edent's Usual Occu	ipation		16b. Kind of B			
715	n n	Completed	(Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	life	e kind of work done DO NOT use retir	e during most of wor ed)	king				
21		E 0	12	02	1	Teacher			Educat	ion		
Þ	be filed stal Hygi d other event, I	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	, Maiden Sumar	ne)		
<u>a</u>	2 9 2 0	ည	William Joseph	h Cram	e		Helen		Lieb			
Maryland 21215-0036	and h		19a. Informant's Name/Relationship (Type	pe, Print)	1	-	at and Number or Ru		-	State, Zip	Code)	
	D € 2 ±		Pamela Sue Bystra	k/Daughter	the state of the s		1 Road, S		le, MD	2178	4	
ore	00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other pl	асе)	Date	20c. Location	City or To	wn, State	
Ē	Pages ment of ant: If It ury or o		4 □Donation 5 □ Other (Specify)		Evergree	n Mem. Ga	rdens 6/2	7/06	Finksbuı	eg, Ma	arylan	d
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Furieral Service Vision	aut		22. Name and Addi Lemmon Fu	ress of Facility neral Hom lonia Road	e of Du	laney Va	11ey 2109	Inc.	
	_		23a. Part1. Enter the disease, or compli	ications that caused th	ne death. Do not e					210	Approximate	
ı			shock, or hear failure. List only or immediate Cause Final	ne cause on each line							Onset and D	
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):						1 da	4,
	Examiner			000 W (01 a3 a	consequence or,							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):							
	uted	Examiner	Cause (Disease or injury that initiated events									
ó	en ar		resulting in death) Last	Due to (or as a	consequence of):					- 14		
68760,	tificete be executed ng physicien and as the burial-transit	edlcai		d								
	E D d	-	IF FEMALE:									
Вох	eath cert ettendin for use	an/	23b. Was decedent pregnant in the past 12 mg/fths?	3c. If yes, outcome of 1☐Live birth 2	Fetal death	□Ectopic pregnan	су			ite of defive onth	-	'ear
0.	The law requires that the death cer sie hes been signed by the ettendir bage 2 should be detached for use	Physician/A	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me of death 5	Other (specify)					-,	
<u>م</u>	thet the de led by the detached it		Part II. Other significent conditions con	ntribution to death but	not resulting in the	underlying cause o	rven in Part I	23e. Did 1	tobacco use con	tribute to th	ne cause of de	eath?
Records,	signe d be	d by	brady anx	hy thous	a .	,··· 3	,	1 🗆	Yes 2.⊠No	3 ☐ Prob	ably 4 ⊟U	Inknown
Ö	w requii	Completed	h	I like	Dot			24a. Was	246	Mara auto	-au findings s	
3ec	e lav	m	in an rian	FIGNE	umon			auto	psy ormed?	prior to cor death?	psy findings a mpletion of ca	luse of
a								1/2 Yes		1 🗆 Yes	2(2 No	
Vital	sician: T certificet rector, pa	Be	25. Was case referred to medical examiner?	Hospital:	• • • • • • • • • • • • • • • • • • • •	-5	ther	ath (Check only				
ō	Phys r this ral dir	5	27. Manner of Death	28a. Date of Injury (Month, Day		ent 3L DOA	4 Nursing F		now injury occur		Y)	
o	iding Ph Ih. After th funeral	ş	1 Actural 5 Pending 2 Accident investigation	(Month, Day	Year) Infun		onk?]Yes 2∐No					Mary Control
Division	or Attending Physician: after death. Director: Atter this certifici in by the funeral director. I	100	3 Suicide 6 Could not be	28e. Pface of Injur	y - At home, farm,	street, factory, office	9	28f. Location (Street and Num	ber or Rura	I Route Numi	ber,
ā	s efter al Direct ad in by	Certification:	4 nomicide	building, etc.	(Ѕреспу)			City or To	wn, Siale)			
	To the Hospital or Attentwithin 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s))
	o the	Me	29b. Signature and title of certifier	0			nse number		29d. Date signe	ed (Month,	Day, Year)	
	- < - ō		Nikhil Ala	arnal,	MD	RE	9-000)	Tuno	22	-,20	16
	: 0		30. Name and address of person who co	ompleted cause of dea	ath (ftem 23a) (Tvo			7	1 11		10-6	
	10		21.101.1	wal p	10 5	inai t	10) pital	of k	Balle,	nors	2 .	
	Sta	ate	31. Date fifed (Month, Day, Year)	32. Angistrar	's Signature	hast.	1	1				
	Regist	rar	JUNZ 7 Z	JUD MARKE	and Silve I	ENTERED		-				

State of Maryland / Department of Health and Mental Hygiene 2 () 0 6 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Riddile Month **Physician** June civa 2006 4:32 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Randallstown Baltimore Sorthwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Yrs. Director 212-20-7386 Maryland 81 Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other then "natural", or items 23a or 28a-f ehow traumatic event, the Modical Examiner must be notified at 1 □ Yes 2 1 No Director Baltimore Owings Mills 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 U.S.A. 10111 Lyons Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced WW II White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor FMC Corporation 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 end 2 should be Health and Mental Burkett Nina C. Riddle Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 10111 Lyons Mill Road Mary L. Riddle Owings Mills, MD other Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H importent: If ite eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 6/29/06 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Sles ELINE FUNERAL HOME Reisterstown, Maryland 21136 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascelar Disease Atheroscherotic /Medical Due to (or as a consequence of) Examiner las a conscion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Diabetes resulting in death) Last Due to (or as a consequence of): O. Box 68760. Physician/Medical trostate Se attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death signed by the al 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 1□ Yes 2 No of Vital : After this certification funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one 2 X R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu s efter death. 1 Tes 2 No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Principles of the best of my knowledge death incurred at the time. *155 and office to the causa(s) and office at stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0055644 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer You've DO Northwest Hospital 5401 old Course Rd. Randallstown MD 21133. 31. Date filed (Month, Pay, Xear) 32 Registrar's Signature State Registrar

			For State Registrar	State of Marylan				ealth and Death	Mer		giene Reg. No	2000	20126
			1. Decedent's Name (First, Middle, Last)						2.	Date of Dea Month	ath Da	ay Year	3. Time of Death
	Physicia /Medic		Albert Pa	ul Roho	le					June 2		2006	3:00 a ^M
	Examin		4a. Facility Name (If not institution, give st			4b. City,	Town, or	Location of De	ath		40	c. County of Death	
			Stella Maris	Hospice			Tows						timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under Months	r 1 Year Days	If Under 24 H Hours Mi		Date of Birt (Month, Day	h y, Year		place (State or Foreign intry)
	Director		163-07-7158	95	Yrs.				Αι	1g. 1	4,	1910	PA
	pu *		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	daryli eho	ō	MD Bal	timore	T	oist	ersto	nt.m					1 □ Yes 2 No
	28a-1	Director	10e. Street and Number	CIMOTE		10f. Zig		JWII			10a. C	itizen of What Cou	intry?
	ath with the Marylan 23s or 28s-f show	ā	102 Rockrimmo	n Dood			2113	36			9	U.S.A.	•
	ne 23	Funeral		2. Was Decedent Ever in U	.S. 13. V	Vas Dece		spanic Origin? n, Mexican, Pu	(Specify	y Yes or No-	- 1	14. Race - Amer	ican Indian,
	fler d	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1				erto Ric	an, etc.)		Black, White	, etc.
8	urs af	Ď	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		I □ Yes	2 X No	Specify:				Specify:	White
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2121	thin ?	혈	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT U	se retired,	luring most of w	9				
2 2	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or iteme 23a or 28a-f ehow ent, the Medical Examinat natal be multified at	Completed	8		Sa	les						Auto Par	ts
ᇃ	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the M	Be	17. Father's Name (First, Middle, Last)					18. Mother's N		-11			
¥ ¥	2 should be to and Mental I is marked or raumatic eve	ပ္	Oscar Charl						he1i			Pantke	
Maryland	2 sho and is m		19a. Informant's Name/Relationship (Typ	•	19b. Mailin	g Address	s (Street a	und Number or	Rural R	oute Numbe	er, City	or Town, State, Z.	ip Code)
	ges 1 and 2 should it of Heelth and Mer If Item 27 is marke or other traumatic		Paul Rohde	Son	102 F			n Road	Rei			n Mary 1 Location - City or 1	
Baltimore,	Pages 1 nent of H int: If Ite	10	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, cren	natory`or (other place	. 1			206. L	Location - City or i	own, State
altim	permit. Page Department of Important: If eny injury of		4 □ Donation 5 □ Other (Specify)					n Gard	6/28	3/06	Co	ckeysvil	le, MD
38.	ermit lepar mpor ny in		21. Signature of Funeral Service Licenses	1				s of Facility				erstown	
	405 e d		sephen 1									wn, Mary	1and 21136 Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations thaticaused the deat e cause on each line.	n. Do not ent	er the mod	de or dyling	g, such as card	liac or re	espiratory ar	rest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	CHRONIC OBST	TRUCTEL	PUL	MONA	RY DISE	ASE				
	/Medical Examiner		resulting in dealin)	Due to (or as a conseq	uence of):								
	LAdillille	_	Sequentially list conditions, b.	Due to (or as a conseq									
10.	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	delice oi).								
Br	and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
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	icate phys s the		d .										
9 X	eath certific ettending p I for use es I	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pregna	ancy						ŀ	23d. Date of delin	verv
Вох	eath etter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d		Ectopic p Other (s)						Month	Day Year
P.O.	at the de by the o	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
	£ 28	by PI	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco	use contribute to	the cause of death?
a Sp	quires n sign	Q D								101	Yes 2	2□No 3□Pro	bably 4 X Unknown
ROHDE Records,	w requir been si should	Completed								24a. Was		24b. Were aut	opsy findings available
S S	he lav e has	E							-		rmed?	death?	ompletion of cause of 2 ☐ No
ALBERT of Vital	hysicien: The la nis certificate ha I director, page 2	a	25. Was case referred to medical					26. Place of D	eath /C	1 ☐ Yes		io To res	2 140
ALBERT of Vital	s cert	To B	avaminar?	ospital:	ER/Outpatien	t 3 🗆 D	OA Othe	\r.				6 X Other (Spec	(b) HOSPICE
-	조 근 전		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury Work					ury occurred	,, 100111011
<u>.</u>	# - * 2 3	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Monas, Buy rous)	mjury	М		Yes 2∐No					
Division		III C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factor	y, office		28f	Location (S City or Tox		and Number or Ru	ral Route Number,
Ö	s afte	Certification;		3,		_							
	To the Hospital or Attent within 24 hours after deatl To the Euneral Director: completely filled in by the	Medicai		ician: To the best of my known: On the basis of examination and manner stated.									
	To the within: To the comple	Me	29b. Signature and title of certifler			29	c. License	number			29d. D	ate signed (Month	, Day, Year)
	- \$ - ō		17-				Du	3725	_			6/24,	106
	ì		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Tvpe.		- (2123				0,-4	06
	6		DR. TARIO MAHMOOD				D. '	TIMONIU	M. N	D 210	93		
	Sta	ate	31. Date filed (Month, Day, Year)						, 4				
	Regist		JUN 2 7 2006	32 Registrar's Signa	F ROS	W.							

DHMH 17 Rev 1/2001

JUNE 25, 2006 3:00 a.m.

ALBERT ROHDE

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 2006 Month **Physician** 6:28pm Edith Rohlfing June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lutherville Baltimore 7 Westbury Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 4, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₹ F 404-28-3532 Director 79 Yrs Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show Its Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Lutherville Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7 Westbury Road 21093 U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) IOth grade College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If Item 21 is marked other the eny injury or other traumarth. Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hoskins Marie Messer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Rohlfing, Jr./Son 7 Westbury Road, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery June 26, 2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, MD 23a. Patt Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORD lein Cerree **Physician** mall 5 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a Phys 9 Unknown ste has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☑ No 1 Yes 2 No : After this certifications a funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ENo 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide etifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D19714 30. Name and address of person who compl eath (Item 23a) (Type, Print) JHBUML 4940 BAITERY AVE BALTIMENE PUNTEH MI LYARK 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** June 20, 2006 Stephen Spearman 5:15 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1 M 2 □ F 265-39-7021 47 Dec 20, 1958 Director Florida Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel', or iteme 23s or 28e-f show with jury or other treumatic event, the Mardical Examilier must be notified at once. 1 Tes 2 No by Funeral Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Lake Claire Drive 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 carpenter self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katie Pugh ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floretta Spearman/spouse 1005 Lake Claire Drive Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Emeral Survice Licensee Wade, State Anatomy Board 655 W. Baltimore Street inn Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** wos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, becoming to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the buriel-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the ettending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA hours efter death. Ineral Director: After this y filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Vatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral C 1 Centrying Physician: To the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Annapolis, ma, 21401 Bestrate Road elouicu, mo 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 20129 1 - Stata Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician June 19, Thomas C. Simmons 2006 5:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Rel Air Harford 8. Date of Birth (Month, Day, Year) Nov 14, 1920 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2□ F 85 Director Pennsylvania 192-14-1336 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-1 show the Medical Examiner must be notified at Harford Bel Air 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Bynum Hills Circle 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 'ages 1 and 2 should be filed within ont of Health and Mental Hygiene. It: if item 27 is marked other than "y or other traumatic event, the Ma. Elementary/Secondary (0-12) College (1-4or 5+) 12 chemist APG 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Lowe Simmons Julia Elizabeth Sander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Simmons/spouse 2706 Bynum Hills Circle Bel Air, MD 21015 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ∑Donation 5 ☐ Other (Specify) 21. Signature of Fun at Service Licensee Konald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director mai Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician acute myocardial /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tary, learning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificete 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation d in by the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours aft

To the Funeral Di

completely filled in 14 Certifying Physician: To the best of my knowledge, death occurred at the time date and place and due to the eauto(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40063138 ne and address of erson who completed cause of death (Item 23a) (Type Print) pper Chesapeake Ix. Bel 41r, MD 21014 TRH 32/ Registrar's Sign ture 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 2 7 2006

		For State Registrar	State of Mary		epartment of Certificate		Reg	ene 2006	2013
Physic /Medi		1. Decedent's Name (First, Middle, I		1400	1		2. Date of Death Month	Bay Year 8	3. Time of Death
Examile Funeral Director	ner	4a. Facility Name (If not institution, g 5. Social Security Number 63-26-6122 Usual Residence of Decedent	sayor	PHSI n yrs. last birth 84	day) If Under 1	Year If Under 24 Hr. Days Hours Min	s. B. Date of Birth	4c. County of Death 9. Birth Cot 1922 Penn	place (State or Foreigntry)
Maryland -f ehow	_	10a. State 10b. County	10	C. City, Town	or Location				10d. Inside City Limits
the Marylan r 28a-f ehow notified at	recto	MD Balt 10e. Street and Number	imore	Mi	ddle Riv		100	3. Citizen of What Cou	1 ☐ Yes 2 ☐ No untry?
death with the me 23s or 28s	ralD	13 Windlass Dr				1220		USA	
	by Fune	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Amed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		13. Was Deceder II Yes, specify 1 ☐ Yes 2 X	nt of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White Specify: wh	, etc.
21215-0036 d within 72 hours after giene. or then "naturel", or ite	Completed by Funeral Director	15. Decedent's (Specify only highest of Elementary/Secondary (0·12)	Education grade completed) College (1-4or 5+)	- '	Decedent's Usual (Give kind of work of life. DO NOT use	done during most of w	orking 16	Sb. Kind of Business/I	•
- 5 × 5 ±	Be Co	17. Father's Name (First, Middle, La	st)		spector	18. Mother's Na	ame (First, Middle, Ma		use
Men Men atic	2	Edward David SI 19a. Informant's Name/Relationship		19h	Mailing Address /9	Effie Is	sebelle Ver		in Codel
C a = a		Franklin Square	Hospital 93	00 Fra	nklin Squ	are Drive	Rosedale,	MD 21237	<i>p</i> 0000)
Pages 1		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	20b. Place of l cemetery	Disposition (Name , crematory or othe	er place)		oc. Location · City or I	
Balti permit. Depertm imports eny inju		21. Signature of Progral Survice L	wade Divec	tor	State A Baltimo	Address of Facility Inatomy Boa Pre, MD 21	rd 655 W.	Baltimore	Street
Physician (ficate be executed buysician and physician and strength of the phristicans).		Immediate Cause (Final disease or condition resulting in death) Security is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence o	·):	Lon C	ancer		6 mon
O. Box 6. Ithe death certiff by the attending ached for use as	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the common of the co	Fetal death	3 ☐Ectopic preg 5 ☐ Other (spec			23d. Date of delin Month	very Day Year
cords, Pwrequires their been signed beto should be det	₽	Part II. Other significant conditions	s contributing to death but n	ot resulting in	the underlying cau	se given in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pro	
Vital Reco	Completed						24a. Was an autopsy performe 1 Yes 2	24b. Were aut prior to death?	opsy findings availa ompletion of cause 2 No
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ision o ktending Pr death. ctor: After th	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ha		ury M	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		
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the Hospitei hin 24 hours e the Funerei I	Medical	29a Certifier	Physician: To the best of n raminer: On the basis of ex and manner stated	amination and	Jeath contined at or investigation, in	the time, date and place my opinion, death occ	ourred at the time, date	se(s) and manner as e and place, and due	stated, to the cause(s)
To th withir To th comp	Ž	29b. Signature and title of certifier	15 51	MT		icense number		Date signed (Month	
7		30. Name and address of person wi	no completed cause of deat	h (Item 23a) (ype, Print)	2006191		6/20/	
	tate	31. Date liled (Month, Day, Year)		124 Signature		trenue,	isultin	whe, M	D 2122
Regis			2006 Deserte	, B.	Spark				

State of Maryland / Department of Health and Mental Hygien 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June **Physician** 25, 2006 Robert G. Strader Sr. 9:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Owings Mills Baltimore 858 Queens Park Drive 8. Date of Birth (Month, Day, Year) Aug 25, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1(X) M 2□F Months Days Hours 84 West Virginia 234-30-0526 1921 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland if Hygiene.
other than "natural", or Items 23e or 28e-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ?7 Is marked other than "natural", or Items 23e or 28e-f show traumatic event, tra Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 858 Queens Park Drive 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1942 If Yes, Give Year or Dates: 1945 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 □Widowed 4 □Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any liquy or other traumatic event 90Rg. Be Audra Strader Maude Peterson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Strader Jr. /Son 858 Queens Park Drive Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/26/06 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Doensee
Thomas Gregor ^{22. Name and Address of Facility}
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 BUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certitier 29c. License number 6-26-06 D005640 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) Gary Yurow 1838 Green Tree Road Suite 535 Pikesville, MD 21208 31. Date filed (Month, Day, Year) JUN 2 7 2006 3. Registrar's Signature State Registrar

		1	For State Registrar	State of Maryl		artment of F			iene 2 0	06	201	32
\$ 0 °	Ye.	-	1. Decedent's Name (First, Middle	Last)				2. Date of Dear Month	Day	Year	3. Time of [Death
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157 - 520	amine		a. Facility Name (If not institution,			4b. City, Town, o		eath	4c. County		_	
	76		8610 Snowden R					Hro a service A Sinth		Howar		C
Fun				6. Sex 7. Age (In)	rs. last birthday,	Months Days		Min. (Month, Oay	Year)	Coun		roreign
Direc	ctor		579-38-4248 Usual Residence of Decedent		74 Yrs.			JUL 25,	1931	Kans	sas	
rland ow	12	-	10a. State 10b. County	10c	. City, Town or L	ocation				10	d. Inside City	/ Limits
Man,	ie.	र्व	Maryland Howa	ard		Coli	mbia				1 🗀 Yes	2 X No
h the	Total	l'ed	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Coun	try?	
th wit	2	<u>8</u>	8610 Snowden Ri	ver Parkway, A	pt. 215	2104	+ 5		Ţ	JSA		
dea	E.	Iner	11. Marital Status	12. Was Decedent Ever	n U.S. 13.	Was Decedent of H	lispanic Origin' an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		e - Ame <i>ric</i> ck, White, (
d 21215-0036 (iled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show	E	by Funeral Director	1 Never Married 2 Marri	If Yes, Give		1 ☐ Yes 2X No	Specify:		Specif	V: T.Tl	. .	
21215-0036 9d within 72 hours aff rgiene. er then "natural", or	EX	D D	3 XWidowed 4 □ Divorced	Year or Dates:	16a Daga	dent's Usual Occup	ation		16b. Kind of B	Whi		
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withi than	2	E .	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak	rer		()wn Ho	ome	
Hyg ethe	ent,	BeC	17. Father's Name (First, Middle, I	ast)				Name (First, Middle,	Maiden Suman	ne)		
land be	S S	TO B	Albert Colvi	n]	Maude Godb	old			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thems 23a or 28a-1 show	amma amma		19a. Informant's Name/Relationsh	iip (Type, Print)	19b. Mail	ing Address (Street	and Number o	r Rural Route Number	; City or Town,	State, Zip	Code)	
and and a salth n 27 i	er tru		Teresa M. Hei		the second second		ville R	oad Laurel				
Baltimore, permit. Pages 1 a Department of Hee important: if Item	t of		20a. Method of Disposition 1 □ Burial 2 □ Cremation		b. Place of Disp cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location	City or To	wn, State	
Pag ment	nu		4 □Donation 5 □ Other (Sp		etro Cre	matory,]	$[nc. \perp 6]$	/26/06	Baltin			
Salt ermit.	eny In		21. Signature of Funeral Service I	icensee	2	2. Name and Addre	ss of Facility	Cremation	Society	of N	D, Ind	2.
	e a		Edward A. G	regorchik				ad Baltim		2122	28 Approximate	
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Physic			Immediate Cause (Final disease or condition resulting in death)	-a Cong	estur	e near	r ka	elyse				
/Med Exam			resulting in douting	Due to (or as a sor	nsequence of):	- Mis	mark	alyre lessos a	_			
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√ per	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		U							
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Box 68 death certifica e attending ph	r use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		Ectopic pregnancy	v			te of delive	-	ear
	ed for	Physician/Med	in the past 12 months?	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify)			IVIC	onth	Day Y	o ai
\$ = 5	detached	Phy	9 ☐ Unknown Part II. Dther significant condition	use contribution to death but no	t reculting in the	andorhaing on uso an	on in Part I	23e Did to	bacco use con	tribute to th	e cause of de	eath?
	8	2	Part II. Diller significant condition	nis contributing to death but no	resulting in the	dideliying cadse giv	on in racci.	1	es 2 No		ably 4 □U	
ecords, law requires t	should	etec										
Rec The law te has t	3028	Completed			<u> </u>			= 24a. Was a autops perfor	sy .	prior to cor death?	osy findings a npletion of ca	use of
_ 0	r, page	င္ပ	25. Was case referred to medical							1 🗌 Yes	2□ No	
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	eral d	\vdash	27. Manper of Death	28a. Date of Injury	28b. Time			28d. Describe h			,	
2 = 5	Ę	atlo	1 Matural 5 ☐ Pendin 2 ☐ Accident investig		ar) Injury		Yes 2 □ No					
Division I or Attending after death. Director: Afte	by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		At home, farm, s	treet, factory, office		28f. Location (S City or Tow	treet and Numi	oer or Rura	Route Numb)0 <i>f</i> ,
Div tal or rs afte al Dir	n be	Cer										
Division To the Hospital or Attendation 24 hours after death To the Funeral Director:	ely fil	cal	(Check only 2 Medical	g Physician: To the best of my Examiner: On the basis of exam	knowledge, dea mination and/or i	th occurred at the til	me, date and p opinion, death o	place, and due to the coccurred at the time, o	ause(s) and mi	anner as st	ated. the cause(s)	
the hin 2	mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		9d. Date signe	d (Month	Day Year	
or viti	3		1 MILIN	1/.71		12	247		T	26		
m		-	20 Nemo and address of property	who completed cause of death	(Item 23a) /Tues	Print	11-1		June	26,	2006	
ני	,		RAHUL GIL	STRA MD.	12016	GEOR	GIAI	re wh	evian	20	902	
400	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	1 4						
Re	egistr	_	JUN 2 7	2006 Lineur	J. A	and .						

		•	For State Registrar	State of	Maryland		artment <i>rtificate</i>			nd Me		giene Reg. No. (2006	20133
	Physicia		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic	al	JAMES MELVIN								June	24	2006	
)	Examin	er	4a. Facility Name (If not institution,	give street and num	iber)		~	town, or	Location of	f Death		4c. C	ounty of Death	1
	Funeral		5. Social Security Number	S. Sex	7. Age (In yrs. las	t birthday)	If Under		If Under 2	24 Hrs.	B. Date of Birti	h	9. Birth	nplace (State or Foreign
L	Director		214-40-8924	1 X M 2□ F	64	Yrs.	Months	Days	Hours	Min.	(Month, Day APRIL	/, Year)	Co	NY
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1		anting							101
	Aaryla Fahov	5	MD 100. County			BALTI								10d. Inside City Limits 122 Yes 2 □ No
	28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	untry?
	h with	<u></u>	2224 DRUID HILI	AVENUE			2	1217	1				USA	•
	deat	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Orig	in? (Spec	ify Yes or No-	14	Race - Amer Black, White	
36	or it	by Fu	1 Never Married 200 Marrie	d 1XX es If Yes, Give	2 □ No 9	1	1 ☐ Yes 2		Specify:			S	Coorify:	
21215-0036	be filed within 72 hours after death with the Maryland that lygiene. ad other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, the Medical Examinar must be notified at	ed b	3 Widowed 4 Divorced 15. Decedent's	Year or Da		16a. Deces	dent's Usua	l Occupa	ation			16h King	ىلكا of Business/l	ACK
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pu	should be filed withir nd Mental Hygiene. marked other than Imatic event, I'm M	Be	17. Father's Name (First, Middle, L.	ist)							First, Middle,		umame)	
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Ma			KATIE SALTUS/WI						LL AV		BALTIMO		Town, State, Z	217
ē,	of Health of Health (20a. Method of Disposition			e of Dispo	sition (Nam natory or ot	e of	a1	Da	te	20c. Loca	ation - City or	Fown, Slate
Ë	Pege nent o nt: If iry or		¶∏Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		state		FORE			6-29	-06	OWIN	GS MIL	LS, MD
Baltimore, Maryland	permit. Peges 'Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Li	censee										NS F.H., INC.
	20 E E 9		James a	. mor	ton					-	BALTIN		MD 2	1217
			23a. P. ft. Enter the disease, or of shick, or heart failure. List of	omplications that ca nly one cause on ea	used the death. ach line.	Do not ent	er the mode	e of dying	g, such as o	cardiac or	respiratory ar	rest,	- 1	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	- thy			1 24	nds	me					week
	Examiner			Due to (r as a consequer	nce of):) U							
	4,	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a consequer	nce of):								
	nd and read	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
90,	oe exe	EX	resulting in death) Last	Due to (or as a consequer	nce of):								
8760,	death certificate be executed eattending physicien and a for use as the burial-transit	dicai		d										
9 X	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnanc	y						23	ld. Date of deli	ven
. Box	death e atter	iclar	in the past 12 months?	4□Pregna	nth 2∏ Fetal de ant at time of deal		Ectopic pro Other (spe					-	Month	Day Year
P.O.	the the	hys	9 🗆 Unknown	9∐ Unkno										
		<u>م</u>	Part II. Other significant condition	s contributing to de	ath but not resulti	ng in the u	nderlying ca	ause give	en in Part I.					the cause of death?
ord	v requir been si should	ed								-	1 U Y	'es 2□	No 3□Pro	bbably 4 Hinknown
Vital Records,	2 5 6	Completed									24a. Was autop	an sy	24b. Were autoprior to death?	topsy findings available ompletion of cause of
Ta I		မ င်	25. Was case referred to medicat						00.51	(0)	1 ☐ Yes	2/2 No	1 🗆 Yes	2 No
	Physician: r this cartific ral director,	To B	examiner?	Hospital:	npatient 2 EF	VOutpatier	nt 3□ DO	A Othe	200		(Check only o		Other (Spec	wfv1
20	ter thi		27. Manner of Death	28a. Date o		3b. Time o		8c. Injun			d. Describe h			, , , , , , , , , , , , , , , , , , ,
Siol	Attending F r death. ector: After by the funer	catic	2 ☐ Accident investiga	ation	, , ,		М		Yes 2□N	No				
Division of	or Atten after deati Director:	Certification;	3 Suicide 6 Could no 4 Homicide determin	289. Place	of Injury - At hom- ig, etc. (Specify)	e, farm, str	eet, factory	, office		28	If. Location (S City or Tow		Number or Ru	ral Route Number,
_	hours a uneral C		29a. Certifier 1 Certifying	Physician: To the	best of my knowle	edne deat	h occurred :	at the tim	no date and	d place, an	nd due to the	Salico(c) a	nd manner as	stated
	To the Hospital or At within 24 hours aftar of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examination	n and/or in	vestigation,	in my or	pinion, deat	h occurred	at the time,	date and p	lace, and due	to the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier		-		29c	License	number				signed (Month	
			France Mag	no Mana	~ m	P	_ P	18!	559			June	24,	2006
4	H		30 Name and address of person from the Thomas	to completed cause		3a) (Type. Mem	6	20-	+ B	Baltu	nove	MI	2120	2006
	Sta Registi		31. Date filed (Month, Day, Year)	32, R	egistrar's Signatur		de							

DHMH 17 Rev 1/2001

JAMB MELIN SALTAS

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Carol Lee Shimer-Sidor

		1- For State Registrar		Сe	rtificate o	f Death		ar riygione	Reg. No.	200	6 201
Physic	ian							2. Date of D	eath		3. Time of Death
ledical Exam	ııne	COLOT THE DITTIE	r-Sidor					June 26	, 2006	Year	0122 hrs
		4a. Facility Name (if not institution, given Johns Hopkins Bayview M				-	, or Location o	f Death	4c. (County of Death)
Funera		5. Social Security Number 6. So		- /1-		Baltimore					
Director			1		last birthday)	If Under 1 \	Year If Under Days Hours		Birth(MM/DI	D/YYYY) 9 Bir Foreig	thplace (State or
			M 2X F	4	O Yrs		110010	04/2	9/1966	6 Co	untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Locat	on					
*	١.	Maryland			timore	OII					10d Inside City Limits
faryland 28a-f show 1 at once.	평	10e. Street and Number		Lai	CINOLE	106 7:-0-4					1 Yes 2 No
or 28	Director	6407 Danville Aver	110			10f. Zip Code 21 224				n of What Cour	ntry?
215-0036 be filed within 72 hours after death with the Maryland mail Hygiens mail Hygiens ket other than "natural", or items 23a or 28a-f she ent, the Medical Examiner, must be notified at once.			12. Was Decedent	Ever in Li	S 12 Wa					5.A.	
eath v item ust h	Funeral	1 Never Married 2 Married	Armed Forces?			es, specify Cut	nispanic Origi pan, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	No- 14	 Race - Americ White, etc. 	can Indian, Black,
fter d		3 Widowed 4 Divorced	If Yes, Give Year	X No	1	Yes 2 X	No specify:			Wh	ite
ours a atura	d b	15. Decedent's Education (Specify or	or Dates: nly highest grade com	pleted)				nd of work done	Action and the Control	d of Business/Ir	
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	during mo	st of working I	ife. DO NOT u	se retired)	TOD. KILL	d of Dusiness/II	raustry
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5-0 ifed v Hygir forthe							18.Mother's	Name (First, Middle			
21215-0036 buld be filed within 72 I Mental Hygiene marked other than '	8	Marvin Laford Shim	er				Dorot	thy Roseb	erry		
D 2 shoul and M 7 is m	ြို	19a Informant's Name/Relationship (T Timothy Sidor (Hus			19b. Mailing	Address (Str	eet and Numb	er or Rural Route No	mber, City o	or Town, State,	Zip Code)
ore, MD es I and 2 sho of Health and If item 27 is	(L)	20a Method of Disposition	Danu)	1005	Place of Disposi	anvill	e Aveni	ue, Baltin			
Baltimore, MD 2 sporting Pages 1 and 2 shou Department of Health and Numportant: If item 27 is no njury or other traumatic		1 Burial 2 X Cremation 3	Removal from Sta	te C	crematory or oth	er place)		Date		ation - City or T	
ti Par timeni rtant		4 Donation 5 Other Specify:	·	Bay	view Cr	remator	y,Inc.(06/28/2006	5 Balt	imore,	Maryland
Baltimore permit. Pages I Department of E Important: If i	-	21. Signature of Funeral Service Licen	500		22. Na	me and Addre Rr	ss of Facility	ski Funera	al Hom	D D 7	
Physician		23a. Part. Enter the disease, or compl	ications that sourced	ha daash							land 21221
/Medical		and c. List only one cause on ea	on line,	ne death.	Do not enter th	e mode of dyin	g, such as can	diac or respiratory a	rest, shock,	or heart	Approximate Interval Between Onset and
Examiner		or condition constitues in shorth)	Multiple Injuries Oue to (or as a conse	~	Λ.						Death
			ode to (or as a conse	quence or):						
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec								
uted Id ansit		events resulting in death) Last	ode to (or as a consec	querice of	<i>}.</i>						
7760, ficate be executed g physician and sthe burial - transit	n/Medical	UNPENDED	AMENDED								
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death Funeral Director: After this certificate has been signed by the attending physici rely filled in by the funeral director, page 2 should be detached for use as the buri	Med	IF FEMALE:	23c. If yes, outcome	e of orego	ancy				Time a		
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	death 3	Ectopic pi	regnancy	23d, Da Moi	ate of delivery nth Da	y Year
O. Box 6	Physicia	1 Yes 2 No 9 ✔ Unknown	4 Pregnant at ti	me of dea	ath	er (Specify)					, .cu
the de	Phy	Part II. Other significant conditions	9 Unknown	h 4 4							
of Vital Records, P.O. in Physician: The law requires that the law trequires that the offer this certificate has been signed by neral director, page 2 should be detach	þ		continuating to death	but not re	sulling in the un	deriying cause	given in Part I				e cause of death?
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tal Rection: The certificate ector, page	ပ္ပြဲ	····						perfo 1 ✓ Yes	rmed?	death? 1 ✔ Yes	2 No
ician:	Be	25 Was case referred to medical examiner?	espital:				e of Death (Ch	neck only one)	L		
Physical direction	유	1 Yes 2 No 27. Manner of Death	i inpatient		R/Outpatient				Residence	-	
ding h	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month Day Yea Jun 25, 2006	r)	28b. Time of Inju 2227 hrs	· 1 '	ury at Work?	28d. Describe Driver auto		ccurred	
Division tal or Attendir rs after death al Director: A	ati	2 Accident Investigation	ı L			- 1	Yes 2 V No	2			_ [
Divi	틥	Suicide 6 Could not be determined				factory, office	building, etc.	or Town, S	itate)		Route Number, City
the Hospital hin 24 hours the Funeral		29a Contition	(Specify) Majo					Southeast r	ear Easte		rds, Essex, MD
	ica	(Check only one) 1 Certifying Physicial 2 Medical Examiner:	n: To the best of my li On the basis of exami	cnowledge nation and	e, death occurre	d at the time, d	late and place,	and due to the caus	e(s) and ma	nner as started	
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated					red at the time, date			
		Que D				29c. Licen:			Ι.	signed (Month)	Day, Year)
		20 Name and sides of			0.1	0.0.	M.E.		June 26	5, 2006	
5		30. Name and address of person who co Ana Rubio MD. Assistant	mpleted cause of dea Medical Examir			not Politica	ore MD 04	204			
	200	31. Date filed (Month, Day, Year)	32. Resistrar's			eet, Baltim	ore, MD 21	∠U1 —————			
Sta	:1(:I	o. Date med (MOTHI, Day, Year)	AS 32. Redistrar's	orgnature		N.					

		1	For State Registrar	State of I	Maryland		artment <i>rtificate</i>			and Mei		ene2	006	20135
3.			1. Decedent's Name (First, Middle, La	st)						2.	Date of Deatl Month		Year	3. Time of Death
80 -	Physicia /Medic		ROSA SHO	RTER							UNE 23	, 200		4:00 A M
	Examin	er	4a. Fecility Name (If not institution, give	street and numb	er)		4b. City, T			of Death			nty of Death	ATT.
4	3.4%	~	113 WELLS AVE. 5. Social Security Number 6. S	ev 7	Age (In yrs. Ia	ast hirthday)	GLEN If Under 1		NLE If Under a	24 Hrs. 8	Date of Birth		ARUND 9. Birth	
day.	Funeral Director			□M 2 X F	87	Yrs.		Days	Hours	Min	(Month, Day,	Year) 1919	ITAI	place (State or Foreign htry) Y
83	D.		Usual Residence of Decedent	.1										
	arylan show	_	MARYLAND ANNE ARU	MDET		n, Town or Lo								1 ☐ Yes 2 🔯 No
	8a-f	Director		NDEL	GLE	N DUKI	10f. Zip 0	Codo			1/	o Citizon	of What Cou	
	with t	급	10e. Street and Number				210					•		,
	ne 23	era	113 WELLS AVE.	12. Was Decede		S. 13.	Was Decede	nt of His	panic Orig	gin? (Specif	y Yes or No-	14. R	STATE lace - Ameri	can Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examiner must be inclified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	(XNo		fYes, specif	-	Specify:		an, etc.)	Spec	lack, White,	etc. HITE
9	72 hou	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual	Occupat	tion	t of working		16b. Kind of	Business/In	dustry
215	within 7 lene. then "r	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	retired)	g					_
21	filed w Hygier Sther th		17. Father's Name (First, Middle, Last,	2		HOME	EMAKER		18 Mothe	r's Name (F	irst, Middle, N		N HOME	
anc	ntal H	Be C	GIUSEPPE ANTON		T.I.T					ELA TI			amoy	
Ž	2 should be and Mental is marked of surmatic ever	၉	19a. Informant's Name/Relationship (DDI	19b. Mailie	ng Address (Street as			oute Number,	City or Tov	vn, State, Zij	Code)
S	nd 2 still ar 27 is r trau		KAREN SHORTER / I	AUGHTER		899 I	LAURIE	KAN	E G	LEN BU	JRNIE,	MD 21	061	
re,	s 1 and 2 of Health itsm 27 i		20a. Method of Disposition	3D Ct		lace of Dispo	osition (Name	e of ner place) !	JUNE	26,	20c. Locatio	n - City or T	own, State
E	Page nent c ant: if		1 A Brazial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Special		DUI	LANEY	VALLEY	MEN	1. GA	_		IMONI	UM, MA	ARYLAND
Baltimore,	permit. Pages 1 Depertment of H Important: if its eny injury or ot once.		21. Signature of Figure II Serving Lice	ns ee			2. Name and IRKLE 21 CR				RAL HO	ME, P	A. IE. MD	21061
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death									Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. U	(en	9								Wee k
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	e au	0	\cap	,				
	- Administra	_	Sequentially list conditions, if any, leading to immediate	b	as a consequ	Ster	e uu	سا		1 see	s e			
Г	nted Insit	Examine	Cause, Enter Underlying Cause (Disease or injury											
ر م	be executed icien and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
8760,	cate be executed oblysicien and the burial-transit	dical		_ d										
9	ng ph as th	d)	IF FEMALE:											
Вох	death certifica e attending ph id for use as th	Iclan/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal	l death 3[☐Ectopic pre						Date of deliv Month	ery Day Year
<u>o</u> .	the check	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnar 9□Unknow	nt at time of de n	eath 5	Other (spe	спу)						
Q	that the ed by detac	/ Physi	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the u	inderlying ca	use give	n in Part I.		23e. Did tob	acco use c	ontribute to t	he cause of death?
ds,	es De pe	d by									1 □ Ye	s 2 No	3 □ Pro	bably 4 Unknown
of Vital Records,		ompleted									24a. Was a	n 24	b. Were auto	opsy findings available ompletion of cause of
Re	The law ate has b page 2 sl	E O									autops perform	ned?	prior to co death? 1 \sum Yes	
ital		0	25. Was case referred to medical						26. Place	of Death (C	Check only on			
T	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inp	patient 2	ER/Outpatie	nt 3 DO	Othe	^[] 4 □ Nu	ırsıng Home	5 🔀 Reside	nce 6 🗆 (Other (Speci	fy)
			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		Work			d. Describe ho	w injury occ	curred	
sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not be		f Injune - At he	omo form et	M least factors		'es 2 🗌		Location (St	root and Nu	mber or Pur	al Route Number,
Division	i dite	Certification:	4 Homicide determined	building	f Injury - At ho j, etc. <i>(Specif</i>)	y)	reet, ractory,	onice		201	City or Town	, State)	moer or Hur	ai nobie ivalibei,
	pita Surs eral	1 1	29a. Certifier 1 K Certifying P	hysician: To the b	est of my kno	wledge, deat	th occurred a	it the time	e, date an	nd place, and	d due to the ca	use(s) and	manner as s	stated.
	To the Hos within 24 h To the Fun completely	edical		miner: On the bas and manne	is of examina									
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		2			License					ned (Month,	
)			* Mer	2018		/	D3	1551			J	UNE 2	3, 200)6
	10		30. Name and address of person who RUSSELL R. DELUCA					BAL	TIMOF	RE, MA	RYLAND	21230)	
33	Sta Regist	ate	31. Date filed (Month, Day, Year) JUN 2 7	32. R	istar's Signa	iture				_,				
P.	negist	rell	JUN A I	1000	Mary	0 1	100AF	P						

-04363			ease Type or I					
bin Ann Shee		State of Ma 1- For State Registrar	aryland / Depar <i>Cert</i>	rtment of He dificate of De			eg No. 200	6 2013
Physicia	ın/	Decedent's Name (First, Middle,Last)				2. Date of Deal		3. Time of Death
ledical Exami		Robin Ann 4a. Facility Name (if not institution, give street		eks	. Town or Location	June 22, 2	2006	0334 hrs
		Franklin Square Hospital	and number)		y, Town, or Location sedale	or Dearn	4c. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 1 1 M 2	7. Age (In yrs. las	Mo	nder 1 Year If Und nths Days Hour	s Min.	th(MM/DD/YYYY) 9. Bird Foreign	
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City. 1	Town or Location				10d. Inside City Limits
<u> </u>		Maryland Baltimore		Dundalk				1 Yes 2 XNo
Maryland 28a-f show d at once.	Director	10e. Street and Number			Zip Code	11	0g. Citizen of What Cour	ntry?
ith the M 23a or 2 notified		2908 Plainfield Road			21222		USA	
Baltimore, MD 21215-0036 Departir Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In programs: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married An	as Decedent Ever in U.S med Forces? Yes 2 X No	If Yes, sp	ecify Cuban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
s after rral",	ठ	Widowed 4 Divorced If Yes, G or Date: 15. Decedent's Education (Specify only higher	S:	1 Yes 16a. Decedent's Us	2 No specify		Specify: Whi 16b. Kind of Business/I	7.7.1.
2 hours a "natura".	eted		lege (1-4 or 5+)		working life. DO NOT		Tob. Kind of Business/I	ndustry
5-0036 ed within 72 tygiene. other than '	Completed	11 years		Waitres	SS		Restauran	ıt
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last)	-			r's Name (First, Middle, M	Maiden Surname)	
2121 uld be fil Mental F marked	To Be	Marshall William Krem 19a. Informant's Name/Relationship (Type, Pri		19h Mailing Addr		orgia Owens mber or Rural Route Num	ther City or Town State	Zin Cada)
MD 2 nd 2 shou lith and M m 27 is n	ř		mother			Road, Dundal		21222
Baltimore, MD 2 permit. Pages and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		20a. Method of Disposition	20b. P	lace of Disposition (Name of cemetery,	June 27,	20c. Location - City or	
MOF Pages ent of mt: 16		1 Burial 2 X Cremation 3 Rem 4 Donation 5 Other Specify:		view Crer		2006	Baltimore,	MD.
Baltimore, permit. Pages I an Department of Hee Important: If ite		21 Signature of Funeral Service Licensee	00	22. Name a	and Address of Facili	al Home Of Point Road,		
	4	Athory Con	welly	7110	Sollers F	oint Road,	Dundalk, MD.	
Physician /Medical		3a. Part I. Enter the alsease, or complications failure. List only one cause on each line.					est, snock, or heart USC	Approximate Interval Between Onset and Death
Examiner			or as a consequence of		and cocarne	use		Dean
		Sequentially list conditions, bb.						
	ine	cause. Enter Underlying Cause	or as a consequence of)):				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	ur as a consequence of	i.				
xecuted n and - transit	_	TX UNPENDED d.	item#23a	,27,28a-f,p	erME.g857/7/	26/06 TT		
50, te be e nysicia	Medi	X AME	item#23a	<u>, perME</u> G	859, 9/28/00	TT	23d. Date of delivery	
5876 ertifica ling ph	an/N	23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal de	ath 3 Ectop	ic pregnancy	· · · · · · · · · · · · · · · · · · ·	Day Year
Box 68760, e death certificate be execute the attending physician and ed for use as the burnal - tran	Physician/Medica	1 Yes 2 No 9 V Unknown 9	Pregnant at time of dea Unknown	other (Specify)			
O. E		Part II. Other significant conditions contrib		sulting in the underly	ring cause given in P	art I 23e. Did to	bacco use contribute to	the cause of death?
P.O ires that to signed by the detact	d by					1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords,	lete					24a. Was autop		topsy findings available ompletion of cause of
Recc The lavicate ha	Completed						med? death?	
Division of Vital Records, tal or Attending Physician: The law require after dealh. all pirctors. After this certificate has been siled in by the funeral director, page 2 should the state of the state	BeC	25. Was case referred to medical examiner?			Othor	(Check only one)		
of Vit ing Physic After this uneral dire	5	1 Yes 2 No	I Inpatient 2	ER/Outpatient 3 ⊌ 28b. Time of Injury	DOA Other		Residence 6 Other	:
ion of tending Pheath.	ion:	1 Natural -	(Month, Day, Year)	Fnd 2:27 ar	407		low injury occurred	
/iSiC r Atte ter dea irector	ficat	2 Accident investigation	e. Place of Injury - At ho			A UIK	Street and Number or Ru tate) 909 Arncli	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executine 24 brours after death. To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial—1	Certification:	4 Homicide determined (S	pecify) found i	n house		or Town, S Essex, M	tate) 909 AMCLI	TT KOAO
e Hos 124 hc e Fun		29a. Certifier 1 Certifying Physician: To						
To th withir To th compl	Medical	2	basis of examination ar anner stated.	icroi investigation, if	29c. License numbe		and place, and due to the 29d. Date signed (Moi	
	2	De dignatoro and ano or contino	11		O.C.M.E.		June 22, 2006	uu, Day, rear)
		30. Name and address of person who complet	ed cause of death (Item	23a)				

State 31. Date filed (Month 19 N Year) 7 Registrar

Theodore King MD.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2006

06-04381 Alec Satisky

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	, , , , , , , , , , , , , , , , , , , ,	C	ertifica	ate of	Death					eg. No.	100	6 2013
Physicia	n/	1. Decedent's Name (First, Mic				СЛТ	ISKY				Date of Dea Month	Day Y	ear	3. Time of Death
ledical Examii		A 4a Facility Name (if not institu	LEC	mber)			D. City, Tow	n, or L o	cation of		June 22, 2	4c. Count	y of Death	
		2135 W. Patapsco A		,			Baltimo							N/A
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birth	nday)	If Under 1 Months	$\overline{}$	If Under	r 24Hrs. Min.	8. Date of Bi	th (MM/DD/YY)	(Y) 9. Bir Foreig	thplace (State or gn
Director		215-56-7942	1[X]M 2 F	57 - -€	59	Yrs.	MOTION	Days	Hours	IVIII I.	06/14	/1947	Co	ountry) MD
Ş.		Usual Residence of Decedent 10a, State 10b, Count		110c C	tv Town	or Locatio	n							10d. Inside City Limits
ow any			BALTIMORE				MILL	ς						1 Yes 2 X No
Aaryland 28a-f show 1 at once.	황	10e. Street and Number	DALTIMONE		- 01	T	10f. Zip Co			-	1	0g. Citizen of V	What Cou	ntry?
the Ma a or 28	Director	7 KING CANU	TE COURT					21	117			USA		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	- a	11. Marital Status	12. Was Dec		U.S		Decedent of				ofy Yes or No		ce - Amer	ican Indian, Black,
r death or ite	Funeral	1 Never Married 2 X	1 Yes	2 X No			_		specify:			Specify	, LII	
rs afte	2	3 Widowed 4 15 Decedent's Education (S	Divorced If Yes, Give Yea or Dates: pecify only highest grad		16a.		s Usual Oc	,		kind of wo	rk done	16b. Kind of I	- 144	HITE
72 hou	ompleted	Elementary/Secondary (0-1			┤ '	during mo	st of workin	g life. D	OO NOT I	use retire	d)			
215-0036 be filed within 7 ttal Hygiene -ked other than ent, the Medical	ם		3		OWI	NER								SERVICES
15-00 filed with Hygien d other	O	17. Father's Name (First, Midd BERNARD	lle, Last)		CV.	TISKY	,	18		s Name (I LEEN		Maiden Surnan	,	EBERMAN
should be filed within and Mental Hygiene 77 is marked other that natic event, the Med	o Be	19a. Informant's Name/Relation	nship (Type, Print)					Street a				mber, City or To		
and 2 should be fil eath and Mental I tem 27 is marked traumatic event, it		DEBORAH SAT		Ε	7	KING	CANU	JTE	COUR	RT -	OWINGS	MILLS	, MD	21117
- p # # #	ļ	20a. Method of Disposition 1 X Burial 2 Cremat	tion 3 Removal fr			of Disposit	tion (Name er place)	of ceme	etery,		Date	20c. Locatio	n - City or	Town, State
Pages lent of ant: If				M	0SES		TEFIOF				5/2006			RPE, MD
The part of the pa														
	\dashv	23a. Part I. Enter the disease,	or complications that c	aused the de	ath. Do no	890 ot enter th)0 RE] e mode of a	STE dying, su	RSTC uch as ca)WN R ardiac or i	OAD - respiratory ar	BALIIM(rest, shock, or l)RE . heart	MD 21208 Approximate Interval
Physician /Medical		failure. List only one cau	use on each line.											Between Onset and Death
Fxaminer		Immediate Cause (Final disea or condition resulting in death			_	Ticad					_	.,		
Same of		Sequentially list conditions,	b		()									
	nine	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate		consequenc	e or).									
New Pige	Examiner	events resulting in death) La		consequenc	e of):									
760, cate be executed physician and the burial - transit	edical	UNPENDED	d. X AMENDED	item#7.	3.28a.	perFH	ME. of	356.6	5/26/0	06 TT				
760, ficate be of g physicia t the buria	/ledi	IF FEMALE:		outcome of p		-			-,,			23d. Date	of delive	ry
687 ertifica ding p		23b. Was decedent pregnant i past 12 months?		oirth	e				Ectopio	c pregnan	су	Month	1	Day Year
Box 68 e death certif the attending	Physiciar	1 Yes 2 No 9	Unknown g Unkn	nant at time o own	i dealii	5 Otr	ner (Specif	/)						
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		Part II. Other significant cor	nditions contributing t	o death but n	ot resultin	g in the u	nderlying c	ause giv	ven in Pa	art I.				the cause of death?
b. P.O. ires that the signed by the detached	d by				<u> </u>									bbably 4 Unknown
ords, aw requii as been 2 should	Completed										24a. Was	psy		utopsy findings available completion of cause of
RecC The lay cate ha	E O											ormed? 2 No	1 🗸 Y	
Division of Vital Records, tal or Attending Physician: The law require rs after death an Director: After this certificate has been si led in by the funeral director, page 2 should b	Be	25. Was case referred to med examiner?	111-111-1						3thor -	(Check o	nly one) Home 5	Residence 6	2 A Oth	Conn
fVi Physic er this	은	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury		outpatient Time of In			y at Work	:</th <th>28d Describe</th> <th>how injury occ</th> <th></th> <th>er, ocerie</th>	28d Describe	how injury occ		er, ocerie
ion of tending Phyerical After the funeral	ion:	1 Natural 5 F	Pending (Mont	h Day Year)	142	9 hrs		1 🗸 Ye	es 2	No S	Subject sh	ot self		
ViSic or Atte fter des Directo	fica			ce of Injury -	At home, f	farm, stree	et, factory, o	office bu	uilding, et	tc.	28f. Location or Town,		mber or R	tural Route Number, City
Division Hospital or Attent 24 hours after death 5f uneral Director: etely filled in by the	Certification:	4 Homicide	determined (Specify	Other (s	• • •						2135 W. P	atapsco Av		Baltimore, MD
To the Hos within 24 ho To the Fun completely		29a. Certifier (Check only one) Certifyin	g Physician: To the be Examiner:On the basis	est of my knov	viedge, de on and/or	ath occur	red at the t	me, dat	te and pla death or	ace, and o	due to the cau	use(s) and man e and place, an	ner as sta id due to '	arted. the cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of ce	and manner	stated					number		-			onth, Day, Year)
	[7.1 0	10 A	0				O.C.N				June 23,		
		30. Name and address of pe	rson who completed car	use of death (Item 23a)							1		
10		Zabiullah Ali, M.D.	Assistant Medi			11 Pen	n Street	Baltii	more, l	MD 212	201			
	tate	21181	2 7 2005 32. F	Registrar's Sig	L	. 1	mels							
Regi		JUN	N 1 (1000)	Chille.	-	RIGINA								
DHMH 17 Rev 1.	2001				U	NIN	· -							

		•	For State Registrar	State of Marylan		rtment of H		nd Mer		giene 10g. Na	11116	20138
			Decedent's Name (First, Middle, Las	")					Date of Dea Month	ith Day	Year	3. Time of Death
	Physici: /Medic		Lorraine F	R. Schemm					une 2		006	6:00 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Death			County of Deal	
	Z**	3	8400 Charles Val			Towso If Under 1 Year		1 Hrs o	Date of Birth		Baltimo	hplace (State or Foreign
	Funeral Director			^{7. Agg} (my/s.)	Yrs.	Months Days	Hours	Min.	Month, Day	Year)	19 Ma	iryland
9,50	ס		Usual Residence of Decedent							0,13	23 110	
	trylan show	_	10a. State 10b. County	10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Ba-fa	Directo	Maryland Baltimor	e T	owson	1						1 ☐ Yes 2 X No
	with t	급	10e. Street and Number	llan Cannat Am	+ 0	10f. Zip Code 21204				iog. Citi	zen of What Co	ountry ?
	ns 23	Funeral	8400 Charles Va	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	ispanic Origii	n? (Specify	Yes or No-		U.S.A.	ncan Indian,
က	ritter d	Fun	1 ☐ Never Married 2 🕅 Married	Armed Forces?	l I	Yes, specify Cuba	n, Mexican, i	Puerto Rica	ın, etc.)		Black, Whit	
93	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:				Specify:	White
5-0	tiled within 72 hours after death with the Maryland Hygiene. Sther than "natural", or flams 23a or 28a-f show shi, Ita Medical Evandrar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-		(Give	ent's Usual Occupa kind of work done of	during most o	of working		16b. Ki	nd of Business/	Industry
12	within	du	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired memaker	9			0	wn Home	
д О	Hygie Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)		ПО	memaker	18. Mother's	s Name (Fi	rst, Middle,			
an	ld be ental ked c	To Be	Harry Wells				Eli:	zabet	n	Bea	sv	
ary	shou and M a mar umat	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a						Zip Code) 21204
Σ	and 2 saith a n 27 i		J. Melvin Schemm	Husband					t, Apt			, Maryland
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	20b. P Removal from State	lace of Disposemetery, crem	sition (Name of natory or other place	e)	Date		20c. Lo	cation - City or	Town, State
Ē	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify	Hil		ervice Co			006	Tow	son	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or items 23a or 28a-f show amortant in jury or other traumatic event, its Medical Exaction must be collined an once.		21. Signatura Tuneral Strvice Licen	500		Name and Addres		Ruc			Funeral yland 2	Home, Inc. 1204
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death one cause on each line.	n. Do not ente		^					Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):							
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9	ng ph	Med	IF FEMALE:									
Вох	death certific e attending pl d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy				2	23d. Date of del Month	ivery Day Year
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٥	the be		Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
ds,	uires sign Id be	d by							1 □ Y	es 2	No 3□Pr	obably 4 Unknown
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ita	icien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place o		heck only or		1 103	2010
of V	× 20	ToB	examiner? 1 ☐ Yes 2 【▲No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nurs	sing Home	5 Resid	ence (5 □Other (Spe	cify)
ū	ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Work			Describe h	ow injur	y occurred	
sio	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No		1 /0	4	111 - 1 - 0	
Division		Certification:	4 Homicide determined	28e. Place of Injury · At he building, etc. (Specifical Control of the control of	ome, farm, stre	eet, factory, office		281.	City or Tow			ural Route Number,
_	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in	edical C	(Cneck only 2 Medical Exam	ysician: To the best of my kno nner: On the basis of examina	wledge, death tion and/or inv	occurred at the time restigation, in my of	ne, date and pinion, death	place, and	due to the o	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number			29d. Dat	e signed (Monta	h, Day, Year)
	F ≯ F 8		· Clear Den Rod	bottwo		DISS	546			Jun	e 23	2006
•	σ_l		30. Name and address of person who	impleted cause of death (Item	23a) (Type,	Print)	2010	o R	120	Ra	Himmi	SUE AM O
	Sta Regista		31. Date filed (Month, Day, Year) JUN 2 7 20	32 Registrar's Signa	ture Sos	whi !	LUE	* 1 D		J. C.	C (CIME)	n. Day, Year) 2006 ne WD 2037
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perMD,g856,6/27/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Thelma Annette Tindall Month 06 930 M **Physician** H NG-1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Anne Arundel Medical Center <u> Annapolis</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 215F Months 85 JAN 30, 1921 133-20-2598 New York Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Zephyrhills Florida Pasco 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 23a or 39148 Flora Avenue 33542 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or Items 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ₩ Widowed 4 □ Divorced δ "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, Ina Madic one. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bank Teller Banking 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Duprey <u>Carrie Sims</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) 382 Yorkshire Lane Riva, MD 21140 Timothy J. Tindall/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 6/24/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature I Funeral Service Licensee

Edward A Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore. MD 21/28 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ERITON 17 5 **Physician** /Medical Due to (ox as a consequence of): 1) (VERTICACY IN Examiner 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical **as** IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctooic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performer 1 ☐ Yes 2 ☐ No 2/No certificate 1 ☐ Yes or Attending Physician: 26. Place of Death Check only one 25. Was case referred to medical Be examiner? Hospital: 1 Arpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c Certification: To 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. ate signed (Month, Day, Year) 29c License number 29b. Signature and title of centrie DEFENSE HIGHWAY ANNAPOLIS MOZIYOI Name and address of person 445 KENTA M Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

		•	For State Registrar	State of M	arylan				lealth a	ınd M		giene Reg. No.	2006	2014	
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ath Day	Yeer	3. Time of Death	
	Physici: /Medic		Theod	ore Ken	da11	Twigg	5				June	20,	2006	6:05 A ^A	Λ
	Examin		4a. Facility Name (If not institution, give s)		4b. City	, Town, or	r Location o	f Death		4c.	County of Death		
			Suburban Hospita					ethe		04 U.s.	1		ontgome:		
	Funeral Director		5. Social Security Number 6. Sex 1219-03-8970	T	ge (In yrs. 86	last birthday) Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Birth (Month, Day November	28, 1	1919 Mary	place (State or Foreig intry) 1 Land	ın
	P >		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits	
	aryla ho	5		****										1 □Yes 2 X No	
	15e N	ect	Maryland Montgome 10e. Street and Number	ГУ		Potoma		ip Code				10a. Citi:	zen of What Cou	intry?	
	A PO A	ă	11949 Goya Drive					208.	54				ted Star	•	
	ne 23	era	•	12. Was Decedent		.S. 13. \	Was Dec			gin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Ameri	ican Indian,	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show supportant: If Item 27 is marked other than "natural", or items 20a or 28a-f show appringuty or other traumatic event, I'te Medical Examinar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 🛣 Married	Armed Forces 1 ☐ Yes 2 🕅 If Yes, Give			ir Yes, sp 1 □ Yes		an, mexican Specify:	, Puerto	rican, ecc.)		Black, White	, etc. hite	
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			For State Registrar	te of Maryland	l / Depa <i>Cer</i>	rtment of H	ealth and l Death		giene	006	20142
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			Northwest Hospita	Center		Randal				ltimor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	v. Year)	9. Birthpl Coun	lace (State or Foreign try)
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	and and		10a. State 10b. County	10c. City,	Town or Loc	cation				1/	0d. Inside City Limits
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	th wit	Funeral Director	1103 Wicklow Road			21	229		US	5 A	
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ar)	2 sho and is mu		19a. Informant's Name/Relationship (Type, Pr		19b. Mailin	g Address (Street a	nd Number or Ru	ıral Route Numbe	er, City or To	wn, State, Zip	Code)
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Ba	permit. Pages 1 Department of H Importent; if ite any injury or ot		21. Signature of Funeral Service Licensee	MAL	92	.Name and Addres 200 Libe	rty Rd	., Rand	allst	town, M	D 21133
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Division of	ding F	lon:	1 Natural 5 ☐ Pending	. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2⊡No	28d. Describe h	now injury oc	curred	
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	To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physicien 2 Medical Examiner: Call Medical Ex	To the best of my know in the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	e, and due to the urred at the time,	cause(s) and date and pla	I manner as sta ce, and due to	ated. the cause(s)
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			> 4/300lon MD			128	462		June	23, 2	006
	10		30. Name and address of person who complet	thwest has		Center	r Page	lalistow	n 11/2	milan	21133
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 20143

		I- For State Registrar		Cer	tificate c	of Death	7			F	Reg No.	21	JU	201	14
Physicia		1. Decedent's Name (First, Middle,Last)								Date of Dea		Year	3.	Time of Death	\neg
ledical Exami										Month June 17,	Day 2006	rear		1727 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death										ounty of E	Death		\neg
		Route 648 at Linden Lane Glen Burnie								Anne Arundel					
Funeral	╗	5. Social Security Number	7. Age (In yrs. la	. Age (In yrs. last birthday) If Under 1			1 Year If Under 24Hrs.			rth(MM/DD				┪	
Director			1 XM 2 F 32		Y		Months Days Hours		Min.	10/06/			oreign Count	y) MD	
	-	unknown Usual Residence of Decedent	72 J2						1	10/06/1973 Co				,, LID	\dashv
any	H	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits													ts
ž .	- 1	MD Anne Arundel Glen Burnie											Yes 2 X N	lo .	
Aaryland 28a-f show 1 at once.	힐	MD Ann 10e. Street and Number		Glen Burnie					10g. Citizen of What Country?					\dashv	
Mar r 28a	Director			Tot. Zip Gode						rog. Citizer	TOT VVII at	Country	•		
ith the Maryland 23a or 28a-f sho notified at once.		354 Thelma A		21061							USA				
ms 2	Funeral	11. Marital Status	A	cedent Ever in U.	U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto								Indian, Black,		
deat or ite must	5		1 Yes	1 Yes 2 X No			-								
after al", iner	à	Widowed 4 Divorced If Yes, Give Year or Dates:			1 Yes 2 X No specify:					Specify: White				e	
21215-0036 uld be filed within 72 hours after Mental Hygiene, marked other than "natural", e event, the Medical Examiner												d of Busin	ess/Indu	istry	
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)									1				
O30 rrthin	티	10	Waterproofing					Construction				ction	_		
5-0 led w Hygid othe		17. Father's Name (First, Middle	e, Last)		18 Mother's Name ((First, Middle, Maiden Surname)				\Box	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Michael E. To	dd, Sr.	Ruby K.											_
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	2												p Code 2 1 1 1 7	\neg	
MD id 2 sho lith and in 27 is	ı	Ruby K. Todd	Moth	er	6 Bi	tterr	oot (Court	, Ap	t. F,	Owin	gs M:	i11s	, MD	1
e, le, land land Healthealth		20a. Method of Disposition			Place of Dispo		e of ceme	etery,	D	ate	20c. Loc	cation - Ci	ty or To	wn, State	\neg
nt of tr. If		1 X Burial 2 Crematic		crematory or other place)					/06 P :				- 1		
Baltimore, permit Pages I an Department of Her important: If ite	}	4 Donation 5 Other S		Saints Cemetery 6/22					2/06 Reisterstown, MD 11824 Reisterstown Road						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.		X le a la ca	m	Lonk	2	line			am 0	Reis					
Physician	- 1	23a. Part I. Enter the disease, of	or complications that										_	Approximate Interva	ai
/Medical		failure. List only one caus	e on each line.				, , , ,					,		Between Onset and	
≒xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
		b													
	ᆲ	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence o	f);								_	· · · · ·	\dashv
	딀	cause. Enter Underlying Cause													
	Examiner	events resulting in death) Last Due to (or as a consequence of):													
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nrial se	Physician/Medical	UNPENDED	AMENDED												
8760, tificate be ng physici as the buri	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy									23d. E	23d. Date of delivery			\neg
∞ = 3 s	an/	23b. Was decedent pregnant in past 12 months?	Fetal death 3 Ectopic pregnancy					Month Day Year				- 1			
Box e death c the atten ed for us	Sic	Yes 2 No 9 Unknown 9 Unknown									1				- 60
P.O. Box 68 s that the death cert gned by the attendir detached for use a	흔	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23a Did	tobacco use	o contribu	to to the	cause of death?	
ires that the signed by t	ģ									23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown					
S, F uires an sign Id be									_						
cords, law requir has been s	Set									24a Was auto	psy			sy findings available pletion of cause of	
Rec(The la icate ha	Completed										ormed? 2 No	dea	th? Yes	2 No	
tal Recinian: The certificate		25. Was case referred to medic	cal			2	6.Place o	f Death (Ch	neck only						\dashv
Division of Vital Records, tal or Attending Physician: The law require safter death. al Director: After this certificate has been si led in by the funeral director, page 2 should b.	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene													
of Ving Phy After th		27. Manner of Death	28a. Date	e of Injury	28b. Time o	f Injury 2	8c. Injury	at Work?	28	d. Describe	how injury	occurred			\dashv
Division of ' pital or Attending Ph ours after death. teral Director: After t filled in by the funeral	Certification:	1 Natural 5 Pending Jun 17, 2006 1726 hrs 1 Yes 2 No								Passenger auto auto collision					
iSiC Atte r dea rector	cat		estigation 28e Pla	ce of Injury - At h	home, farm, street, factory, office building, etc.				28	28f. Location (Street and Number or Rural Route Number, City					
Div al or s afte of in	ij	Suicide Could not be determined (Specify) Legal Charact								or Town, State)					'
ospit hour nners		4 Homicide Court Citreet Route 646 at Lindert Larie , Glett Burtile, IVID													
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	ical	29a. Certifier (Check only 1 Certifying Physiciag: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) Wedical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
To t	Medical	and manner stated												_	
	2	290. Signature and title of certif		29c. License number					29d Date signed (Month, Day, Year)				⊔ay, Year)		
				O.C.M.E.					June 18, 2006						
71		30. Name and address of parso	Court of the court	,	,	1000	72.0				William Fr				
1		Mary G. Ripple MD.	Donuty Chief	Madical Eva	miner 1	11 Penn S	Stroot	Raltimore	e. MD	21201					- 1
\	20 30		Deputy Chief	R.			olieet,	Daitimore	-,						_ !
S Regis	tate	31. Date filed (Month, Day, Yea		egistrar's Signat		uli)	otreet,	Danimore	,		· · · · · · · · · · · · · · · · · · ·		-		\neg

DHMH 17 Rev 1/2001

Registrar

JUN 2 7 2006

			For State	State of Marylan		artment of			iene _{eg. No.} 20 (16 20	1145
			Registrar Decedent's Name (First, Middle, Last	st)		imodio o	Douil	2. Date of Deat	th		of Death
	Physici /Medic		Mildred Le	e West				JUNE JUNE	oay on z	oo6 9.	20A M
į	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deal	h	4c. County of	1	
			Howard County	reneral hospi-	tal	If Under 1 Yea		8. Date of Birth	How		to or Foreign
	Funeral Director		5. Social Security Number 6. s 579-26-9824	ex 7. Age (In yrs.	Yrs.	Months Day			Year)	O. Birthplace (State Country)	
	D		Usual Residence of Decedent					1/181	183		,
	anylar show	_	10a. State 10b. County		ty, Town or Lo						City Limits es 2⊠No
	28a-f	ecto	MD Howar	d (CO	lumb	10f. Zip Code			0g. Citizen of Wh.		
	with with the party	ä	7212 E-lan Ro	my Doile		2104	1.) .		11C /	at Country:	
	deeth with the Maryland me 23s or 28a-f show (must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Nas Decedent of	Hispanic Origin? (S	Specify Yes or No-		American Indian,	,
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	i	r res, specπy Cι 1 ⊡ Yes 2 ⊠ N	iban, Mexican, Puèr o <i>Specify:</i>	to Hican, etc.)	Specify:	White, etc.	
003	72 hours after "natural", or Ite	d by	3 Widowed 4 Divorced	Year or Dates:						Black	
21215-0036	in 72 in main	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occ <i>ki</i> nd of work don DO NOT use reti	e during most of wo	rking	16b, Kind of Busin	ness/industry	
212	d within giene. or then	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Youc	her E	Kaminer		HUD		
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	1 1			18. Mother's Na	me (First, Middle, I	Maiden Sumame)		
Maryland	ges 1 and 2 should be filed within 72 hours atler deeth with the Marylar It of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Madisal Examinar must be notified at	ဥ	19a, Informant's Name/Relationship	White	10h Mailie	an Address /Stra	Blanck et and Number or R		te.	nto Zin Codo)	
Mai	th and the modern traum		John Robert W	-	7217		2 1 0				70
ē,	es 1 ar of Hea I Item		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other p		Date	bia MI 20c. Location - Ci	ity or Town, State	· ·
E	Page nent o ant: If ary or		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)	Hemoval from State	reen			21/010 1	20Him	Re, MD	
Baltimore ,	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service Licer	1500	22	Name and Add	ress of Facility GREENE	Funeral	SVC		
	g0==9		Yaugho C	. (Treene	51	151 Balt	o Nati Pix	ie Baltin	noce MI	Approxim	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		er the mode or d	ying, such as cardia	c or respiratory arm	95 1,	Interval E Onset an	Between
1	Physician /Medical		disease or condition resulting in death)	a. SEPSI Due to (or as a conseq						day	٢
	Examiner		Conventially list conditions	b. END S		OE R	ENAL	DIS EA	BE	mon	tho
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of):			2			
	be execute iclen and burial-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ELECTRO Due to (or as a consequence)	uence of):	EA	BNORI	YHCIT	157	dan	٠٠٠
8760,	icate be executed physiclen and s the burial-transit		(d CORON			7 ERY.	DISERS	E	mor	ens
9	daath certificate a attending phys d for use es the	Physician/Medical	IC CCMAIG.								
Box	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnature 1 Live birth 2 Feta	death 3	Ectopic pregnar	ісу		23d. Date of		Year
P.O. E	that the daath certif ed by tha attending detached for use et	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of o 9☐ Unknown	feath 5□	Other (specify)				. ouy	7 341
	res that ti igned by be detac		Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause (given in Part I,	23e. Did tot	bacco use contribu	ute to the cause of	of death?
of Vital Records,	w requires been sign should be	ed by						1 □ Y€	es 2□No 3	□ Probably 4	Unknown
eco	S S S	Completed						24a. Was a		re autopsy finding or to completion o	
<u>=</u>		Con						perform 1 Yes	med? dea 2□No 1□	ath?]Yes 2□ No	
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			mar.	ath (Check only on			
ō		. To	1 Yes 2 No 27. Manper of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. In	ury at	dome 5 ☐ Reside	ow injury occurred		
io	Attending r death. ector: After by the fune	atlo	→ Natural 5 Pending 2 Accident investigation		Injury		ork? □Yes 2⊡No				
Division	l or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, offic	8	28f. Location (St. City or Town	reet and Number n, State)	or Rural Route No	ımber.
Ω	Hospital of Ponts at Funeral Ditely filled in		29a. Certifying Ph	nysician: To the best of my kno	awledge death	a coourned at the	time, date and place	and due to the or	auco(c) and mone	os an stated	
	I 4 II 0	Medical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time, di	ate and place, and	d due to the cause	3(S)
	To the I within 2 To the I complet	Ž	29b. Signature and title of certifier	1			nse number		9d. Date signed (/		,
•	do		Spe	pre MD		DO	05315	0 1	75/E 10	15n 20	006
1)		30. Name and address of person who		п 23a) (Туре, 96 S:	Print)	05315	lood.	sulte	110	2004
	Sta	ate	31. Date filed (Month, Day, Mars)	200 6 32. Red Strar's Signa		drails)	- Trapo		_ 010	12016	61073
	Regist		0011 % [The state of the s	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ∠ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:25 PM JOSEPH 2006 hac una 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA Medical Center altimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | Dec 24, 1947 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1XM 2□ F Alabama 58 Yrs. 214-52-9121 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "netural", or Iteme 23a or 28a-f ehow th and Mental Hygiene. 27 is marked other then "netural", or Items 23s or 28s-1 show treumstic event, the Medical Examinal most be notified at 1X Yes 2 No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21225 USA 3 Washburn Avenue Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1968 If Yes, Give Year or Dates: 1971 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny lighry or other treumatic event once. Be Albert P. Weber Elsa Joyce Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9454 Common Brook Road Apt. 101 Owings Mills, MD 21117 Angela J. Weber / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. | 06/27/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Supsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). 50 Examiner End Stage Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been signed page 2 should be Stage Renal Disease 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an 2 No certificate 1 ☐ Yes After this certification funaral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1) Natural 2 Accident To the Hospital or within 24 hours after death.
To the Funeral Director: After completely filled in by the fun Injury investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide r🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar who completed cause of death (Item 23a) (Type, Print)

10 \mathcal{N} . Registrar's Signature June 24, 2006

Baltimore, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 9 per 1h 8856 6-29-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 6 1 - For State Ragistrar 20147 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 Thomas W. White 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7733 Donegal Bay Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 17, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9 NEW Place Charles Foreign **Funeral** Months Days Hours 1X M 2□ F 74 Yrs. Director 141**-**24-0861 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f show the Medical Exactly stringst by notified at 1 ☐ Yes 2 ☐ No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21060 7733 Donegal Bay Drive **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1950

If Yes, Give Year or Dates: 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: 3 ☐ Widowed 4 ☐ Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: if item 27 is marked other tt
any injury or other treumatic avant, tha 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas J. White Agnes Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. White Jr./Son 1369 Clauverwie Middleburgh, NY 12122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/27/06 Metro Crematory Inc. Baltimore, Maryland ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Ligensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician 110 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1□ Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death |Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 ☐ Accident 5 Pending Injury t hours after death.

Funeral Diractor: Aft
ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe

DHMH 17 Rev 1/2001

State

Registrar

Nime and address of person who completed cause of death (Item 23a) (Type, Pript)

1. Date filed (Month, Day, Year)

JUN 2 7 2006

32. Registrar's Signature

							partment of H IE G856,06 Prifficate of L	<u> </u>		2. Date of De	ney. No.		3. Time of De
Physicia		Decedent's Name (First, Mic	ddle, Last)							Month	Day	Yea	ar A · L >
/Medica	al	buen			FEBER		45 City Town or	Location	of Donth	00	02	200 county of D	*
Examine	er '	4a. Facility Name (If not institut	_				4b. City, Town, or		or Death				ORE CITY
			6. Sex	MARYL		rs. last birthday	If Under 1 Year		24 Hrs.	8. Date of Bi	rth		Birthplace (State or F
uneral irector		5. Social Security Number 218-42-8694		M 2☐¥F	62	Yrs.	Months Days	Hours	Min.	(Month, D	194		ary Land
Hector	-	Usual Residence of Decedent											
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			1. Decedent's Name (First, Middle, Last	1)					2. Date of De		6/14/	2006 Year	3. Time of Death
	Physicia /Medic		Doris	Wines					07			925	08-56 AM
	Examin		4a. Facility Name (If not institution, give		.4		y, Town, o	r Location of Death		4	c. County	of Death	71
			Johns Hopki		~ Media		-	imare_	1		1		
	Funeral Director		5. Social Security Number 6. Se 185–18–0726	7. Age	e (In yrs. last bi	Yrs. Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D July 1	19,1	925	Coun	lace (State or Foreign htry) A.
	pu *	}	Usual Residence of Decedent 10a. State t 0b. County		10c. City, Tow	n or Location	-					1	0d. Inside City Limits
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	death with the Maryland ima 23a or 28a-f ahow Imiliat to collified at	Funeral Director	7105 Dunshire Way	Apt B3			212	22			USA		
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036	filed within 72 hours after Hygiene. ither than "natural", or Ita ant, the Madical Examine	þ	1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 □ Yes		Specify:	7 110411, 5101,		Specify		hite
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ම	Health tam 27 tam 27		20a. Method of Disposition		20b. Place of	of Disposition (Nature), crematory or	ame of	Ţ	Date		Location -		
Baltimore, Maryland 21215-0036	Pages nent of int: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Furnal Service Licen.)	I	w Crema	tory	200		$\overline{}$			ty, MD.
Bal	permit. Departn Importa		21. Signature of Francial Service Licent	26/n		Conne 7110	Soll	Funeral H ers Point	iome Of Road,	Dun Dun	dalk, dalk,	P.A. MD.	21222
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P.(that the d ed by the detached	F.	9 Unknown Part II. Other significant conditions or	notributing to death by	ut not resulting	in the underlying	Cauca an	on in Part I	23e Did	tobacco	n use contr	ibute to th	ne cause of death?
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\ <u>\</u>	ysicis is cer direct	To B	exa <i>m</i> iner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3□ [DOA Ott	200	lome 5 ☐ Res		6 □Othe	er (Specif	y)
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-	6)		30. Name and address of person who										
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			For State Registrar	State of Marylar		artmen rtificat			nd Me		ene2006	20150
	Physicia	an	1. Decedent's Name (First, Middle, La Margaret Shirley			· · · · ·			2	Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location o	Death	Succe	4c. County of Dea	
			Baltimore Washir			670	W	ner	ne		Axue A.	Legide C
	Funeral			Sex 7. Age (<i>In yrs.</i> 1 ☐ M 2 ☑ F 83	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min. 8	(Month, Day,	Year) Co	thplace (State or Foreign ountry)
	Director		216-14-2555 Usual Residence of Decedent	0.5		1				07-19-	1922 MD	
	nylanc how		10a. State 10b. County	10c. C.	ity, Town or Lo	ocation						10d. Inside City Limits
	Ba-1 s	cto	MD Baltimo	ore	Baltim							1 ☐ Yes 2X No
	with the and a second	Dire	10e. Street and Number	. 1		10f. Zip				10	g. Citizen of What Co	ountry?
	ns 23	Funeral Director	23 D Arlen Roa	12. Was Decedent Ever in U	J.S. 13.		236 dent of Hi	spanic Orig	jin? (Speci	fy Yes or No- can, etc.)	U.S.A.	
7 0	efter o	Fun	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				n, Mexican Specity:	, Puerto Ri	can, etc.)	Black, Whi	
21215-003	within 72 hours efter deeth with the Maryland ene. than "naturel", or items 23e or 28e-f ehow to Mwdicel Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:								
15 F	n 72 h	Completed	15. Decedent's E (Specify only highest gi	ra de completed)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	iai Occupa ork done d ise retired	ation during most !)	of working		l6b. Kind of Business	/Industry
H 1	y withi	E O	Elementary/Secondary (0-12)	College (1-4or 5+)				nager			Bank	ing
	e filec al Hyg othe	BeC	17. Father's Name (First, Middle, Las		,			18. Mothe	r's Name (First, Middle, M	Maiden Sumame)	
z , ylar	Menta Menta arked	Tof	John Clark Lomax	2						E. Harr	-	
MARNER, Saltimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other treumatic event, the Mudical Examinat must be notified at 20ce.		19a. Informant's Name/Relationship								City or Town, State,	Zip Code)
ARN more, N	1 end Health em 27		Miss Paula L. Wa		Place of Dispo cemetery, cre				Hedge		WV 25427 20c. Location - City or	Town, State
A A	ages ant of it: if it y or o		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						06-28	3-2006	Elkride,	MD
区量	mit. Poartme		21. Signature of Funeral Service Los								Funeral H	
m	Departiment of the particular in the particular		Last to	- noil	20 1	Seco	nd A	ve SW	; G1e	n Burn:	Le, MD 210	61
			3a. Part1 Enter the disease, or cor show, or heart failure. List only	mplications that caused the dea y one cause on each line.	ath. Do not en	ter the mod	de of dyin	g, such as	cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
	*	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a conse	quence of):							
V	cate be executed physicien end the burial-transit	Examiner	that initiated events	C								
ó	be exec icien er burial-ti	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
8760,	cate by	dical	,	d								
9 ×	The law requires thet the death certifical site has been signed by the attending phoage 2 should be deteched for use as the	/Med	IF FEMALE:	23c. If yes, outcome of pregi	nancy					•	23d. Date of de	livery
Box	death atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} 2 \(\sum \text{No}\)	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	□Ectopic p □ Other (s					Month	Day Year
o.	t the c by the echec	hysi	9 Unknown	9□ Unknown						,		
S,	res thet the de signed by the a be deteched t	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying	cause giv	en in Part I.				o the cause of death?
ord	w require been si should t	ted								1 🗆 Ye	s 2 □ No 3 □ P	robably 4 Unknown
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<u>=</u>	ician: The l certificate ha			1						1 ☐ Yes 2	2⊟No 1□Ye	s 2 No
Z.	Attending Physician: r death. ector: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 D	OA Oth	25		Check only on	e] ence 6 □Other <i>(Sp</i> e	noiful
o	g Physical dispersal di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)			28c. Injur Wor				w injury occurred	scily)
io	ittending I death. ctor: Alter / the funer	atlo	1 Natural 5 Pending 2 Accident investigat	ion	injury	М		Yes 2□	No			
Division of Vital Records,	or Atter de Directe in by ti	Certification:	3 Suicide 6 Could not 4 Homicide determine		home, farm, s	treet, facto	ry, office		28	If. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
۵	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physicien: To the best of my ki	nowledge de-	th one	d at the t	ma data :	d place s	ad due to the) (a) and m	s stated
	A Hos 24 hc Fun etely f	edicai		aminer: On the basis of examination and manner stated.								
_	within 2 To the comple	Me	29b. Signature and title of certifier	1				e number		2	9d. Date signed (Mor	th, Day, Year)
			Of Jores 6	Ulamen	_ W	ال	1-	- 46	76	/	Three 2	14 2006
	b		30. Name and address of person what 31. Date filed (Month, Day, Year)	to completed cause of death (It	em 23a) (Type	, Print)	Oppe	wis	me	Phue	2	
m.EE			21 Date filed (Month Day Year)	SEPANISTATE SIN	OR. V	e	(7e	~ 1	burg	shie K	es 206	/
	St. Regist	ate rar	31. Date filed (Month, Day, Tear)	nns samegistrar's sig	G Do	arte						

		•	For State Registrar	State of Man			of Health ar	nd Menta	l Hygien	ZIIII	20151
1	Physicia /Medic		1. Decedent's Name (First, Middle, Las. DRNA W	126140	5			2. Date Mod	77	ay O'G	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	USPITAL		BA	m, or Location of I	rE		c. County of Deat	
*	Funeral Director		5. Social Security Number 6. Security 12–66–1456 Usual Residence of Decedent	M 2 FF	n yrs. last birthday) Yrs.	If Under 1 Y Months Da		Min. (Mo	e of Birth nth, Day, Yea 16, 1	940 Tenn	hplace (State or Foreign untry)
	the Maryland 28a-f ehow	Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number		Oc. City, Town or Lo		de		10g. C	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
036	72 hours after death with the Maryland netural, or Iteme 23e or 28e-f ehow dizal Examiner must be molified at	by Funeral	35 Bishops Lane 11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 [] Yes 2 [X] No If Yes, Give Year or Dates:	er in U.S. 13.	212	28 of Hispanic Origi Cuban, Mexican,	n? (Specify Ye Puerto Rican, (USA 14. Race - Ame Black, Whit	ncan Indian,
21215-0036	within 72 hours aft iene. 'then "netural', or the Madical Exert	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ucation de completed) Cottege (1-4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re	lone during most o etired)	of working	16b.	Kind of Business	Industry
Maryland 2	ould be filed Mental Hygis tarked other tatic event, II	Be	17. Father's Name (First, Middle, Last) Hubert Hopkins				18. Mother		atliff		
	is 1 and 2 sh of Health and item 27 ie m other traum		19a. Informant's Name/Relationship (7) Donna Adcock— daug 20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □	hter	5235 20b. Place of Dispresemetery, cre	Arbutu osition (Name of	r place)	Baltimo Date	ore, ME	21227 Location - City or	Town, State
Baltimore,	permit. Pages Department of I Important: if its eny injury or o		4 Donation 5 Other (Specify)		2. Name and A	al Park 6/ Modress of Facility Kaufman Shington	Funera	al Home	at MMP	Maryland INC.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a o	e death. Do not en	iter the mode of	f dying, such as co PNEC i	ardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death I R A On HLS
Box 68760,	leath certificate be executed ettending physicien and I for use as the burial-transit	by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	□Ectopic pregr				23d. Date of de	livery Day Year
P.O. E	0 0 0	Physici	1 Yes 2 No 9 Unknown Part II. Other significant conditions of	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (special		23	Be. Did tobacc		o the cause of death?
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Division of Vi	ng Phy fter this ineral d	ation: To B	examiner? 1 Yes 2 Yo 27. Manner of Death Natural 5 Pending 2 Accident investigation				Other: 4 Nur Injury at Work? 1 Yes 2 N	28d. D	Residence	6 □Other (Spe	acity)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the f.	Certification:	3 Suicide 6 Could not be determined	building, etc.				Ci	ty or Town, St	ate)	ural Route Number,
	To the Hosi within 24 ho To the Fund completely f	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	nysician: To the best of miner: On the basis of e and manner state	my knowledge, dea examination and/or i ed.	29c. L	icense number		29d. I	Date signed (Mon	th. Day. Year)
	F 3 F 8		30. Name and addres person who	completed cause of dea	ath (Item 23a) (Type	a, Print)	>476	34	J	UME 2	2, 2004 M 21200
	SI	ate	31. Date filed (Month, Day, Year)	0 5 M 32. Registrar	501	ST P	AUC PI	ALE	BALT	71026	10 S1500
	Regist	trar	JUN 2 7 200	b Alfanazo	S. GOS	CER !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month Year JEANNE H. WEST June 22, 8:00 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Greater Baltimore Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 8 / 1 1 / 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 😿 F VIRGINIA 214-14-9612 88 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 No MD LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 BRIGHTWOOD CLUB DR. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12YRS HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES D. HARRISON MARY BOYLAN GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204. 19a. Informant's Name/Relationship (Type, Print) JOHN H. WEST III(SON) 409 WASHINGTON AVE SUITE 1010 TOWSON, MD. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 🕱 Burial 2 □ Cremation 3 □ Removal from State THOMAS G. FOREST 06/26/06 OWINGS MILLS, MD. 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility HENRY W. JENK 16924 YORK RD 21. Signature of Fundal Service License INS & SONS COMONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. CVA 3 Weeks Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Lung CA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? COPD 24a. Was an autopsy 2 🗆 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Man r of Death 1 A atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, s been signe the Hospital or Attending Physician: death. efter death Director: 24 hours e Funerel (

Physician

/Medical

Examiner

Funeral

Director

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other treumatic event,

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 le marked any liquy or other treumatic evone.

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Director

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Examiner

Physician/Medical

Completed by

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Medical Certification: To

29b. Signature

Name and address of person

31. Date filed (Month Day, Year)

State Registrar DHMH 17 Rev 1/2001

ams. M.D

ompleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Monty, Day, Year)

21204

State of Maryland / Department of Health and Mental Hygiene 0 0 6 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JUNE **Physician** 22, 2006 ISABELLE MARY WALKO 10:12 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MANOR CARE-ROSSVILLE ROSEDALE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖸 F Yrs. 12/20/1927 PENNSYLVANIA Director 164-22-0894 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f show the Mudical Exercices must be notified at 1 Yes 2 No BALTIMORE PARKVILLE MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 1761 WHITE OAK AVENUE USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 6 Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 ☐ Divorced WHITE 'naturel' 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other then SALES MANAGER BAKED GOODS permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: if Item 27 is marked other it eny injury or other traumatic event, Ita 2008. 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STELLA BURKE ARTHUR WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHERYL DZWONCZYK/DAUGHTER 121 ELINOR AVENUE BALTIMORE, MD 21236 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition GARRISON FOREST 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/06 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD CEMETERY 21. Signature of Funeral Service Licensee Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASC Physician /Medical Due to (or as a consequence of) Examiner S—pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No certificate has 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: luneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Jo. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After l ⊟Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 🗔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dakwood Rd. Ste 100 Charden 7845 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State of Maryland - State Registrar	-	artment of Heartificate of De		-	giene 200	06 20154
	*		Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physicia /Medic		BEVERLY A. WYNDER				June.	22 20	PUG 11:51 AM
7	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of	Death
		3	UNION MEMORIAL HOSPITAL		BALTIM			N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	* .		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
	Director		218 62 5422 1 M 2 F 51 Usual Residence of Decedent	Yrs.			FEB. 1	8,1955	Maryland
	and			Town or Lo	cation				10d. Inside City Limits
	Mary	ō	MD. N/A	ълтг	TIMORE				1 ☐ Yes 2 ☐ No
	the 28a	Director	10e. Street and Number	_БАЦ.	10f. Zip Code		1	log. Citizen of Wha	at Country?
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or iteme 23a or 28a-f ahow event, the Medical Examiner must be mailfied at		2022 E. 31st. STREET		21218	3		USA	
	me 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. \	Was Decedent of Hispa	anic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian,
9	after or ite		1 Never Married 2 Married 1 Yes, Give X 3 Widowed 4 Divorced Year or Dates:		f Yes, specify Cuban, f t ☐ Yes 2 XNo 5	Specify:	rican, etc.)		White, etc.
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2	han han	m	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired)			C	
	Hygie Hygie ther t		12 TH 17. Father's Name (First, Middle, Last)	MAN	ICURIST 18	3. Mother's Name		SELFEMP Maiden Sumame)	LOYED
au	d be f) Be	WILLIE B. TERRELL			LOLA M			
Maryland	s 1 and 2 should be f Health and Menta item 27 ie marked other traumatic ev	은		19b. Mailin	ng Address (Street amd				ate. Zip Code)
	5 5 5 E		BRONWIND WYNDER-TURNER (dau	thto	-1 2022 F	21.54	cm p	armo mo	21210
ē,	f Hea item		20a. Method of Disposition (20b. Place	ce of Dispo	sition (Name of natory or other place)		ate Date	ALTO, MD 20c. Location - Cit	y or Town, State
9	m O >-		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		LL_CEMET	ਂ ਪਦਸ਼ਨ ਸਮ	NIE 27	ANNE AR	UNDEL, CO.
altimore,	permit. Page Department Important: If any injury or once.		21. Signature 1 Funeral Service Licensee		Name and Address of ALVIN B.				MD.
Ö	P P P P		Bernaden Oscim					LTO MD.	
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.		er the mode of dying, s	such as cardiac o	or respiratory arr	est,	Approximate Interval Between
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	ש ≅	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):	11 1	N			
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence.		HEAT	N' Den.	le_		
8760,	cate be executed physician and the burial-transit		Ce ce bea		10/14/00	Disen.		,	
87	phy:	dical	d		- Jugar	9.	NIC.		
×	certifi Iding	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	;y				23d. Date o	of delivery
Вох	atter atter I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal did 1 Pregnant at time of deal		Ectopic pregnancy Other (specify)			Month	Day Year
P. O.	that the death certific ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown						
	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause given i	in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ğ	w require been sig should b		Diables Melliths				1 🗆 Y	es 2□No 3[Probably 4 Dunknown
Records,	aw re is bee	Completed					24a. Was a	n 24b. Wer	re autopsy findings available
œ.	The law te has page 2 :	E					autops perfori	med?// dea	r to completion of cause of th? Yes 2 □ No
ita	iician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		26	6. Place of Death			
Ž	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien			me 5□Reside	ence 6 □Other ((Specify)
n O	ding Physician: The h. After this certificate hi funeral director, page	ü	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Work?		28d. Describe h	ow injury occurred	
Sio	tendi death tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be			s 2 No	204 1 (0.		0 10
Division of Vital	i or Attend after death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, tarm, str	eet, factory, office		City or Town		or Rural Route Number,
اليبا	pitai ours a erai filled		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge death	occurred at the time	date and place :	and due to the o	ausa(s) and manne	ar as stated
	Hos 24 hr Fun etely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or in	restigation, in my opini	ion, death occurr	ed at the time, d	ate and place, and	due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Me	29b. Signature and title of certifier		29c. License nu	umber	2	9d. Date signed (A	Month, Day, Year)
			Mutual Wanoft M		1)34	680		6-22	2 - 2006
1	77		30 Name and address of person who completed cause of death (Item 2			C	, 0	.1.	-0
				00	2 33-6.	ント #1	36 B	altmore	MD 21218
	Sta Registi		31. Date filed (Month, Pay, Year) 2006 32 Registrar's Signard	te A	SACT.				
	inegisti	-CII							

			For Stata	State of	of Marylan	d / Dep	artment o	of Heal	Ith and	_		2006	201	55
			Registrar			Ce	rtificate	of Dea	aın	2. Date of	Reg. h	N6:- 0 0 0	3. Time of	Doath
	Physicia		Decedent's Name (First, Middle.)	(Last)						Month	1 [Day Year		. M
	/Medic	ai	GLADYS ZURLL 4a. Facility Name (If not institution,	give street and nu	umber)		4b. City, To	wn. or Loca	ation of D	JUNE		2006 4c. County of Deat	1:55	Α Μ
	Examin	CI.	^				BROOKI					ANNE ARUN		
	Funeral		GENESIS-HAMMONDS 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	ear If U	Inder 24 h	Hrs. 8. Date of			nplace (State ountry)	or Foreign
7	Director		219-07-4372	1 ☐ M 2 💢 F	9	7 Yrs.	Months D	ays Ho	ours M		3, 19			
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside Ci	ity Limits
	sho	ō.		DIMET		•							1 🗆 Yes	2XINo
	the N	Director	MARYLAND ANNE A 10e. Street and Number	RUNDEL	<u> </u>	INTHIC	10f. Zip Co	ode			10g. (Citizen of What Co	untry?	
	3a or		322 CHURCH CIRCI	Æ			210	90			UN:	ITED STAT	ES	
	death	Funerai	11. Marital Status		cedent Ever in U	.S. 13.	Was Deceden	t of Hispan	nic Origin?	? (Specify Yes ouerto Rican, etc.	or No-	14. Race - Ame Black, White		
ထ္	or its	E.	1 Never Married 2 Marri		2 X No		1 ☐ Yes 2X			2010 1 110411, 011	,	Specify:	3, 610.	
8	within 72 hours after death with the Maryland ane. Then "netural", or items 23a or 28e-f show the Marical Examiner must be nutitied at	d by	3 X Widowed 4 ☐ Divorced	Year or I	Dates:	10- 0					105	WH	ITE	
<u>7</u>	"nati	Completed	15. Decedent (Specify only highes	t grade completed,		(Give	edent's Usual C e kind of work o DO NOT use i	done during		working	100.	. Kind of Business/	industry	
72	within iene. then	шо	Elementary/Secondary (0-12) 5	College	(1-4or 5+)	TELE	PHONE (PERA	TOR		C	OMMUNICAT	CIONS	
b	Hygid other	Be C	17. Father's Name (First, Middle, I	_ast)				18.	Mother's	Name (First, M	iddle, Maid	len Sumame)		
<u>la</u>	uld be Aental rked o	To B	COLEMAN DOGGET	r					(UNKI	NOMN)				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene "naturat", or Items 23a or 28e-f show them 27 is marked other then "naturat", or Items 23a or 28e-f show other treumatic event, I'm Marylai Examiner must be nutitied at	i d	19a. Informant's Name/Relationsh	nip (Type, Print)		1	_					y or Town, State, 2	(ip Code	
≥, ≤	and ealth m 27		BEN BOSSOM / SON	1	20h I	_	CHURCH osition (Name		LE, I	LINTHIC Date	7	D 21090 Location - City or	Town State	
Baltimore,	ges 1 t of H If Ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		cemetery, cre	ematory or othe	r place)	ไปเป	NE 22,				
Ë	t. Pa rtmen rtent: njury		4 □ Dynation 5 □ Other (Si	pecify)	GLE		N MEM.			2006		N BURNIE,	MARYL	AND
Ba	permit. Pages 1 and Department of Heall Importent: If Item 2 eny Injury or other once.		21. Signature of the control of the				KIRKLE:	Z-RUDI	DICK	FUNERA	L HOM	E, P.A. URNIE, MI	21061	
	*24		23a. Part1. Exter the disease, or	complications that	caused the dea	th. Do not er	ter the mode of	f dying, su	ich as car	rdiac or respirat	ory arrest,	ORNIE, M	Approximat Interval Bet	te
	Priysician		shock, or heart failure. List Immediate Cause (Final			CIE	OTIC	Che	Dia	105011	1 40	DISEASE	Onset and	Death
8.8	/Medical		disease or condition resulting in death)		o (or as a consec		2110	Corre	27104	AJCU	CVVC	DIJCASC	Yen	
	Examiner		Sequentially list conditions	b										
7	sit	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cua to	(or as a consec	quiertoe of):								
V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):					_			
760,	e be ex	calE		d										
687													****	
Box	The law requires that the death certificate ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 ☐ Feta		□Ectopic preg	nancv				23d. Date of del		
-	death	sicia	in the past 12 months? 1 Yes 2 No		nant at time of		Other (spec					Month	Day	Year
P.0	that the de ed by the a detached	Phy	9 Unknown			aultian in the			Dort	230	Did tobacc	co use contribute to	the cause of	death?
	res tha signed I be det	by	Part II. Other significant condition	ons contributing to	death but not res	suiting in the	underlying cau	se given in	rani.	236.	1 Yes		0.00	Unknown
Vital Records,	w require been signal	Completed								242	Was an		itopsy findings	
æ	has ge 2 s	m							-	-	autopsy	prior to death?	completion of o	cause of
<u></u>		မ င်	25. Was case referred to medical				_	26	Place of	Death (Check		No 1 ☐ Yes	2 No	
>	Physicien: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 🗗 No	Hospital:	Inpatient 2] ER/Outpatie	ent 3 DOA	Othor				e 6 □Other (Spe	cify)	
οl	g Phy ter thi	J:U	27. Manner of Death	/A 4c	e of Injury onth, Day Year)	28b. Time Injury	of 280	. Injury at Work?		28d. Des	cribe how in	njury occurred		
Sio	Attending r death. ctor: After by the funer	atic	1 Natural 5 Pendin 2 Accident investi	gation			М	1 🗌 Yes	2 🗆 No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Flat	ce of Injury - At t ding, etc. <i>(Spec</i>	nome, farm, s ify)	treet, factory, o	office			tion (Street or Town, St	t and Number or Ri tate)	ural Route Nun	nber,
	pitel ours a arel D		29a. Certifier 1 Cartifyir	o Physician: To the	ne hest of my kn	owledge des	ath occurred at	the time d	tate and r	place, and due t	o the cause	e(s) and manner as	stated	
	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edicai		Examiner: On the								and place, and due		s)
	ro the vithin ro the ro the round	Me	29b. Signature title of certifie	5	10		29c. l	icense nu	mber		29d.	Date signed (Mont	h, Day, Year)	
		1	15m/	· Wal	lan	und	1)3/1	136	?	Ju	NE 21.	2001	6
	1		30. Name and address of person		h	m 23a) (Type	e, Print)	11.	- 1	00.		Date signed (MONTE) NE 21, DRE MI		
	6		BRIAN C. U	DALLACE		4005	KILL	ok ive	EK	U, BAC	TIM	oke mi	1212	36
45	St Regist	ate	31. Date filed (Month, Day, Year)	7 2006	Palistrar's Sign	lature M	hand !					,		
	riegist	TEN.	2011 2	· COOO	MALIAN	N A	THE WALL							

			1 - State State Registrar	of Maryland	-	artment of a		Mental Hygi	ene _{g. No.} 2006	20156
1	Physici /Medic		Decadent's Name (First, Middle, Last) Euger	e Charles	s Zimm	erman, I	II	2. Date of Death Month June	Day Year 22 2006	
	Examin		4a. Facility Name (If not institution, give street and in 3502 - 7th Street	number)		4b. City, Town, Baltin	or Location of Dea	th	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days			9. Bi	rthplace (State or Foreign Jountry)
	yland now al		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	the Mar 28a-f et	Director	Maryland N/A	В	altimo	re 10f. Zip Code		10	g. Citizen of What C	1 X Yes 2 No
	23a or	ralDI	3502 - 7th Street			21	225		U.S.	,
980	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Erain for must be notified at anotes.	by Funeral	Armed	ecedent Ever in U.S Forces? s 2 🖾 No Give Dates:		Vas Decedent of f Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	within 72 ho ane. than "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 12th	d) (1-4or 5+)	(Give :	lent's Usual Occu kind of work done DO NOT use retire essional	during most of wo	orking	6b. Kind of Business Medical Of	
land 2	ld be filad ental Hygia ked other ic evant, L	To Be Co	17. Father's Name (First, Middle, Last) Eugene C. 2	Zimmerman	II			me (First, Middle, M naBe11e Re	aiden Sumame)	1100
Maryland	ind 2 shou alth and M 27 is mar or traumat	-	19a. Informant's Name/Relationship (Type, Print) $ \begin{tabular}{ll} George E. Finan \end{tabular}$			g Address <i>(Stree</i> - 7th St		ural Route Number. altimore,		
altimore,	Pages 1 a nent of Hei nt: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fro '4 ☐ Donation 5 ☐ Other (Specify)	III State _	_	sition (Name of natory or other pla Crematory			Oc. Location - City of	
Balti	permit. Departm Importa any inju		21. Sign 1 Fun ral Service Licensee	rida	e 40	Name and Addr 201 Ritc	ess of Facility (Sonce Fune	ral Servi more, Mar	ce, P.A. yland 21225
and the second	Pnysician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	each line.	Do not ente					Approximate Interval Between Onset and Death
	/Medical Examiner	_	Sequentially list conditions	(or as a consequence of (or as a consequence)	NIA					4 days
8760,	cate ba executed physicien and the burial-transit	al Examiner	Cause (Disease or injury that initiated events c.	o (or as a conseque					22	20489
9	ertificate I ling physi e as the b	Medical	d					77 - 117 -		
.O. Box	The law requires that the death certific ste has been signed by the atlending p page 2 should be detached for use as	Physician/M	in the past 12 months?	outcome of pregnan birth 2 Fetal (gnant at time of dea known	death 3 🗆	Ectopic pregnand Other (specify)	у 		23d. Date of de Month	Day Year
<u>α</u>	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to	death but not resul	iting in the un	derlying cause gi	ven in Part I.			o the cause of death?
Vital Records,		Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2□E	R/Outpatient	3□ DOA Ot	han	ath (Check only one		scifu)
on of	ding Phy h. After thi funeral o		27. Manner of Death 28a. Dai 1 ■ Natural 5 □ Pending (M		28b. Time of Injury	28c. Inju	ry at ork?	28d. Describe how		Спу
Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ce of Injury - At hon Iding, etc. (Specify)	ne, farm, stre]Yes 2 □No	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attani within 24 hours after deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 12 Medical Examiner: On the and mi	he best of my know basis of examination	rledge, death on and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and due	s stated. e to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	MD			se number		d. Date signed (Mont	th, Day, Year)
	5		30. Name and address of person who completed ca	19 30	015.	(1 Ano	AR SIR	LET, B	NGMP	-21225
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 2006	Registrar's Signatu	Apa.	W				

		1	For State of Maryland / Dep 1- State Registrar Ce	partment of Health and N Pertificate of Death	Mental Hygier Beg. N	ne2006 20157
	Physicia /Medic		1. Decedent's Name (First, Middle, tast)			0ay Year 2006 3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 1088 Pipestem Place	4b. Cily, Town, or Location of Death Rockville J If Under 1 Year If Under 24 Hrs.	l N	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 145-36-1599 6. Sex 1 M 2 TF 60 Yrs.	Months Days Hours Min.	8. Date of Birth Mar. 29, Yes	9. Birthplace (State or Foreign New Jersey
	B Maryland	ctor	10a. State 10b. County 10c. City, Town or	Location CV111e		10d. Inside City Limits 1 ☐ Yes 2 📉 No
	th with th	ai Directo	10e. Street and Number 1088 Pipestem Place	10f. Zip Code 20854		Citizen of What Country? nited States
000	urs after dea ol', or Items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other than "naturel", or items 23e or 28e-f ehow eumatic event, the Mudical Exatural and the notified at	Completed	(Specify only highest grade completed) (Giv	eedent's Usual Occupation te kind of work done during most of work DO NOT use retired) LET	king	Kind of Business/Industry tail Clothing Store
ומוות ד	be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) Calvin Buren		ne (First, Middle, Maid	
	1 and 2 should I Health and Meni tem 27 te marke ther treumatic			iling Address (Street and Number or Rul B Pipestem Place, H		_ '.
saltimore,	2 - 2		TKI Burial 2 Cremation 3 Memoval from State	position (Name of ematory or other place) 06/1 rid Memorial Garder	14/06	Location - City or Town, State
Dair	Department of the partment of		21. Signature of Funeral Serving Licensee	22. Name and Address of Facility Torchinsky Hebrew 1	Juneral Hon	ne
	Pnysician /Medical Examiner	2018	23a. Part1. Enter the disease, or complications that cause the death. Denote shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	()	of respiratory arre	Approximate Interval Between Onset and Death
18/pn,	ate be executed thysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
P.O. Box 62	The law requires that the death certificate be the bese been signed by the attending physic page 2 should be detached for use as the beatened.	Physician/Mec		B□Ectopic pregnancy □ Other (specify)	-	23d. Date of delivery Month Day Year
ń	quires that I in signed by uld be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		to use contribute to the cause of death?
II Heco	The law requir	Completed			24a. Was an autopsy performed 1 Yes 2	
Division of Vital Record	To the Hospitel or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	tion; To Be	25. Was case referred to medical examinar? 1	ent 3 DOA Other: 4 Nursing H	th Check only personne 5 sesidence 28d. Describe how in	6 ☐Other (Specify)
DIVISI	el or Attending s efter death. Il Director: After id in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not e determed 4 Homicide determed 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
	the Hospitel in 24 hours eithe Funeral i	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	and due to the cause rred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the Vithin 2 To the Complete	2	29b. Signaffin and tifle of certifier	29c License number	. 6	Date signed (Month, Day, Year)
	Sta	ate_	30. Name and address of person who completed cause of death (Item 23a) (Typ 31. Date filed (Month, Day, Year) 32. registrar's signature	e Print) Neil Rosensho Medical Civil London	- DALTIN	ore, Mary land 2020

			For State Registrar	State of I	Marylan				lealth a Death	and M		giene Reg. No.	2006	20	158
	90		1. Decedent's Name (First, Middle, Las	1)			-				2. Date of Dea Month	ath Day	Yeer	3. Time of	Death
	Physicia /Medic		Haritini C. Adams								June 9,	-		1:15	a M
4	Examin		4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location o	of Death		4c. (County of Deat	h	
			Holy Cross Hospital						Spring				Montg	omery	
	Funeral		5. Social Security Number 6. Security Number 1	x 7. □M 21x F		last birthday)	If Unde Months	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Ye <i>ar)</i>	9. Birti Co	nplace (State o untry)	or Foreign
	Director					Yrs.					April 1,	1928		Cyprus	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	haryli ho	ō												1 🗀 Yes	2 ⊋ No
	the A	ect	Maryland Montgomer 10e. Street and Number	У	Si	lver Sp	ring 101. Zir	Code				10a Citiz	en of What Co	untry?	
	with read	ā					10		20902						
	filed within 72 hours after death with the Maryland Hygiene. Street han "natural", or Items 23a or 28a-f ehow ent, the Madreal Examinar must be motified at	Funeral Director	2003 Dayton Street	12. Was Decede	ent Ever in U	.S. 13.	Was Dece			gin? (Spe	cify Yes or No-	. 1	4. Race - Ame		
	ter d	F	1 ☐ Never Married 2 ☐ Married	Armed Force	es?				ın, Mexican	, Puerto I	cify Yes or No- Rican, etc.)		Black, White	etc.	
ဗ္ဗ	urs a	by	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yøs	2√ No	Specify:				Specify:	White	
ğ	2 ho	Completed	15. Decedent's Ed			16a. Dece	dent's Usu	al Occup	ation during most	t of working	20	16b. Kin	d of Business/	Industry	
2	Pin 7	ple	(Specify only highest gra	College (1-4	or 5+)	life.	DO NOT	se retired	1)	OI WOIKI	<i>'</i> 9				
7	giene giene th	Ю	6			Sto	rekeep	er					Grocery		
2	al Hy al Hy foth vent	Be (17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)		
ā	Ment Ment arked	일	Christopher Paphit	es						Mai	ria Unkno	wn			
Maryland 21215-0036	and and is my		19a. Informant's Name/Relationship (7				•						Town, State, 2	ip Code)	
≥ .	and Baith n 27		Andrew S. Adams/ Son						, Seve		ark, MD 2				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendle Hygiene. Important: If time 27 is marked other than "natural; or liems 28a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once.		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐	Removal from Sta		Place of Dispo	natory or o	other plac	(9)		ate	20c. Loc	cation - City or	Town, State	
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify		Gat	e of He	aven	Cenet	ery	June 20	006	Silv	er Sprin	. Maryl	and
ä	porting in in in in in in in in in in in in in		21. Signature A Funeral Service Licen	see/					ss of Facilit	•	1				
_	201		Novert /	Sylin			500 Un	ivers	ity Bly	vd, W,	eral Home Silver S	pring	, MD 209	01	
			23a. Part1. Enter the disease; or comp shock, or heart failure. List only	dications that cau	sed the deat th line.	h. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet	w <i>ee</i> n
	Pnysician :	l n	Immediate Cause (Final disease or condition	, Resira	atory Fa	ilure								Onset and	Death
	/Medical		resulting in death)	Due to (or	as a consec	uence of):	1111							A NOW A	
	Examiner		Sequentially list conditions	Pulmona b.	ry Fibr	osis, 1	diopat	hic						7 Years	
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):									
	acute Ind trans	аш	Cause (Disease or injury that initiated events resulting in death) Last	C						-1			_		
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Ŝ	ires the signed I be del	Ď.				auting in the c		3.1				res 2%		_	Unknown
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Vital Records,	: The cate had page	S										2 No	1 🗆 Yes	2 🗆 No	
Žį.	iclen Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth	OF.		(Check only o				
ð	Physiclen: r this certific ral director,	5	1 ☐ Yes 2 ☐ No	Hospital: 1 ∰ Inp 28a. Date of		ER/Outpaties			4 🗀 140				Other (Spec	cify)	
	ling l After Tuner	lo o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month,	Day Year)	28b. Time o Injury	м	28c. Injur Wor	yal k? Yes 2.⊟I		28d. Describe l	iow mjury	occurred		
<u>s</u>	Attending r death. ector: After y the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		f laiunr . At h	ome, farm, st			165 2		ORf Location /	Street and	l Number or Ru	ent Pouto Num	har
Division	or A lifter Direction by	Certification:	4 Homicide determined		, etc. (Speci		eet, lactor	y, office		'	City or Tox	vn, State)	I NUMBER OF THE	iiai noute ivuit	1001,
	pitat ours s eral l	Ö	29a. Certifier 1 Certifying Ph	veician: To the h	act of my kny	nuladae deat	h oncurre	at the tir	no data an	d place of	and due to the	causa/s)	and manner as	stated	
	Fun Fun	dical	(Check only 2 Medical Exam	niner: On the bas	is of examina	ation and/or in	vestigation	n, in my o	pinion, dea	ith occurre	ed at the time,	date and	place, and due	to the cause(s	6)
	To the Hospital or Attending Physiclen: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier	3.0 .1101110			29	c. Licens	e number			29d. Date	signed (Manti	h, Day, Year)	
			X TIL	L				D36	252				-	9, 2006	
7	8		30. Name and address of person who	completed cause	of de th (the	n 23a) /Tuna	Print)							1100	
			Steven Kariya, M.D.			Avenue,		Whea	tan M	D 2090	02				
	Sta	ato.	31. Date filed (Month, Day, Year)					THE ICO	COLI, I'II	2000					
	Regist		JUN 13 20	106	we to	ature	Wes!								

		_	for State Registrar		f Marylan	•	artment tificate			and M		Reg. No.	2006	20159
	Physici /Medic	_	 Decedent's Name (First, Middle, George Josep 		n						2. Date of De Month June	Day 8	Ž O O6	3. Time of Death 7:08 A. M
/	Examin		4a. Facility Name (If not institution, Casey House Mon	tgomery H	lospice		Roc	kvi1				1	County of Death	
	Funeral Director		5. Social Security Number 053-09-2370 Usual Residence of Decedent	6. Sex 1☐ M 2☐ F	7. Age (In yrs.	86 Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da Mar • 2	15, 19	9. Birth Net	place (State or Foreign ntry) V York
	e Maryland 3a-1 ehow	ctor	10a. State 10b. County Maryland Montg	omery		y, Town or Lo								10d. Inside City Limits 1√ Yes 2 □ No
	3a or 28	i Dire	10e. Street and Number 6801 Tildenwood	Lane			10f. Zip	code 20852				-	en of What Cou	ntry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or items 23a or 28a-f ehow event, the Medical Exertifier must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	Armed Fo	2□No Arn	ny	Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1	4. Race - Ameri Black, White Specify: W	
9500-91212	within 72 hou lene. than "netura the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)		dent's Usua kind of wor DO NOT us	k done du e retired)	uring most	t of worki	ng		d of Business/Ir	
_	0 = 0 5	ø	17. Father's Name (First, Middle, L Louis Azralon				2		18. Mothe		(First, Middle	, Maiden S	Sumame)	
	sges 1 end 2 should be nt of Health and Menta : If item 27 is marked or other treumatic ev		19a. Informant's Name/Relationsh Allene B. Azral		ghter								Town, State, Zi Maryland	
Baltimore,	Pages 1 e		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State	Place of Dispo cometery, crem lean Me	natory or of	ther place		/11/	ate 2006		ation - City or T ey, Mar	
Balt	permit. Pages Department of I Important: If ite eny injury or of once.		21. Signature of Funeral Service L	Stote	teny								n, Inc. e, Mary	land 20852
di.	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	a. Stat:	is Epile (or as a conseq	epticus		e of aying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death Days
8/60,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of);								
O. Box 6	The law requires thet the death certificate be executed te has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	tcome of pregna birth 2 ∐Feta nant at time of d own	Ideath 3□	Ectopic pre					23	3d. Date of deliv	ery Day Year
ecords, P	w requires that been signed b should be deta	٥	Part II. Other significant condition	is contributing to d	eath but not res	ulting in the u	nderlying ca	ause give	n in Part I.					he cause of death? bably 4 □Unknown
ľ		Completed									24a Was auto perfo 1 ☐ Yes	psy med?	prior to co death?	opsy findings available impletion of cause of
Division of Vital	or Attending Physicien: 1 Ifter death. Director: After this certifical in by the funeral director, p.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 ENo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigations	28a. Date (Mon	Inpatient 2 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	_	A Other	[□] 4 🗆 Nui	rsing Hor	(Check only one 5 ☐ Resingle Red. Describe	dence 6	X Other (Specioccurred	W Hospice
DIVIS	apital or Attendous after death seril Director: filled in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	ned 288. Place	of Injury - At ho ing, etc. (Specif	ome, farm, str y)	eet, factory	, office		-	28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
	To the Hoepital of within 24 hours aft To the Funeral Discompletely filled in	Medical	29a. Certifier 1 X Cartifying (Check only one) 2 Madical E	Physician: To the xaminar: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	and manner as solace, and due to	stated. o the cause(s)
)	To the comp	Σ	29b. Signature and title of certifier	perme	,		290	D42					signed (Month,	
	B		30. Name and address of person w	no mpleted caus			•	Road	i, Ro	ckvi	11e, Ma			
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Signa						-	-		

		1	For State Registrar	State of Maryla		artment of F		Mental Hy	giene Reg. No. 2006	20161
	Physicia		1. Decedent's Name (First, Middle, Las James Robert	Brown				2. Date of De Month	Day Year	3. Time of Death
	/Medic	-	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	June	9, 2006 4c. County of Dea	2:40 P M
	Funeral		4011 Blackpool F 5. Social Security Number 6. S 577-22-7066		s. last birthday) Yrs.		ville If Under 24 Ha		ay Year) Co	ry thplace (State or Foreign buntry) hington, DC
	Director	-	Usual Residence of Decedent					Joury 1.	, 1313 (105	
	f show	JO.	10a. State 10b. County Maryland Montgo		City, Town or Lo	kville				10d. Inside City Limits 1 Yes 2 No
	r 28a-	irec	10e. Street and Number	MCLY	1100	10f. Zip Code			10g. Citizen of What Co	ountry?
	ath wit	alD	4011 Blackpool F			20853			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I more than "neturel", or items 23a or 28a-f ehow important: if item 27 is marked other than "naturel", or items 23a or 28a-f ehow important: it item 27 is marked other than "naturel", or items 27 is marked other than "action Examinar rount be notified a sone. Once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1943		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	Specify: Wh	te, etc.
21215-0036	in 72 hou "nature	pieted	15. Decedent's Ec (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	rorking	16b. Kind of Business	/Industry
212	d withi	тос	Elementary/Secondary (0-12)	Coflege (1-4or 5+) 4	Se	lf Employ	ed		Constructi	on Contractor
D I	be file tal Hy d oth event,	Bec	17. Father's Name (First, Middle, Last)						, <i>Maiden Suma</i> me) a Schilling	
Maryland	hould d Men marke matic	ဥ	John Aloysius Br		19b. Maili	na Address (Street			er, City or Town, State,	Zip Code)
Z Z	nd 2 saith an 27 is i		James R. Brown,		1	ushmore I			Virginia 22	
nore,	ages 1 and of Hei		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disponentery, cre	osition (Name of matory or other place	Ju	Date ne 13,	20c. Location - City or	Town, State
Baltimore,	Departme Departme Important eny injury		4 Donation 5 Other (Specification of Licer	100	F F		ss of Facility.		Silver Spr l Home Inc ilver Sprin	ing, Maryland
	Physician /Medical Examiner	8)	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to the said cause. Enter Underlying	plications that caused the de one cause on each line. a. Prostate Ca Due to (or as a conse Due to (or as a conse	ath. Do not en					Approximate Interval Between Onset and Death 1.3 Years
68760,	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a const						
.O. Box (that the death certifics ed by the attending pt detached for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify)	/	10	23d. Date of de Month	livery Day Year
σ.	sign sign d be	þ	Part If. Other significant conditions of	contributing to death but not r	esulting in the	underlying cause giv	ven in Part I.		tobacco use contribute t Yes 27 No 3 ☐ P	
Vital Records	The law ate has b page 2 si	Completed						24a. Was auto perf 1 🗆 Yes	opsy prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		- Ott		eath (Check only		
of	ding h. After fune		1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c, Injur	ry at		idence 6 Other (Spe how injury occurred	ocity)
Division		Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, si	treet, factory, office		28f. Location City or To	(Street and Number or Fown, State)	ural Route Number,
	Hosp 4 hou Fune ely fil	edical (nysicien: To the best of my k miner: On the basis of exami and manner stated.						
		Me	29b. Signature and title of certifier	. Hæggerty	mp	29c. Licens			29d. Date signed (Mon	
	5+1		30. Name and address of person who Joseph M. Hagge:	completed cause of death (fi	tem 23a) (Type		<u> </u>	ville, M	June 12, D 20850	2006
in the state of th	St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Sig						

			1 - For State Registrar	State of M	arylan				lealth a Death	and M	ental H	ygien Reg. Ne	2111	06	20	162
	Physici /Medic		Decedent's Name (First, Middle, Edward A. Brown	Last)							2. Date of D Month June	Da	, 006	Year	3. Time of 7:10	f Death
ī	Examin		4a. Facility Name (If not institution, the Holy Cross Hospi)				r Location o			40	ontgo		·	
	Funeral Director	17.0	5. Social Security Number 579–88–1337	.Sex 7.Aq		last birthday, 1 Yrs.		1 Year Days		24 Hrs. Min.	8. Date of B (Month, E March	Day, Year)	Coun	lace (State o try) 3.	or Foreign
	f ahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	nery		y, Town or L thersl								1	0d. Inside C	ity Limits
:	3a or 28e	il Director	10e. Street and Number 17624 Shady Spri	ng Terrace			10f. Zip	Code 0877					itizen of W		•	
036	De lied within /2 nouts atter death with the Maryland tal Hygiene. Ital Hygiene. d other than "natural", or itema 23a or 28e-f ahow event, if a Medical Examinar must be incitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	?	.S. 13.	Was Dece If Yes, spe		lispanic Orig an, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	lo-		, White,		
Baltimore, Maryland 21215-0036	s tiled within 72 nd I Hygiene. other then "natur ent, it a Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or	5+)	(Give		rk done i se retired	ation during most d) Worker		ng	Un	Kind of Bus ited stal	Stat	es	
yland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, La Henry Brown								(First, Middle Wilson		n Surname)		
, Mar	and 2 sn ealth and m 27 ia m ner traum		19a. Informant's Name/Relationship Christiana Brown		1	17624	Shac	ly Sp	pring	Terr	ace, (Gaitl	nersb	urg,	MD 20	0877
Itimore	permit. Pages 1 and 2 should be in Department of Health and Mental I important: if item 27 is marked of any injury or other traumatic ever once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie	cify		Place of Disposementery, cre . Souls	s Ceme	eter	у _	July 2006		Gern	nanto	wn.	_{wn, State} Mary 1a	and
E E	Depa Impo any i		FIRACY A-	tur)		10	East	De	er Par	ck Dr	ive,	Gaitl		-		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heartfailure. List or Immediate Cause (Final disease or condition resulting in death)		hagea	1 Cano		e or dylli	ig, such as	cardiac of		arrest,			Approximat Interval Bet Onset and	ween
	cate be executed by sicien and the burial-transit	ai Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		72.3										
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rds, P.	w requires that it is the position of the posi	Ď	Part II. Other significant condition	s contributing to death t	out not res	ulting in the u	inderlying o	ause give	en in Part I.						e cause of d ably 4.2∑t	
ř	ate h page	Completed								_		opsy formed?	pri	ere autor for to con ath? Yes	osy findings apletion of c	available ause of
	Pnysician: this certifica rai director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2½ No	Hospital: 1 ⊠ Inpati	ent 2 🗆	ER/Outpatie	nt 3□ DC	Oth			Check only		6 Other	(Specify)	
Division of	Affer une	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no		ury Ly Year)	28b. Time o Injury	f Z	8c. Injun Worl	yat k? Yes 2 □ N		8d. Describe	how inju	ry occurred	1		
	크를		4 Homicide determin	ed 28e. Place of In building, e	tc. (Specify	y) 					8f. Location City or To	own, State	θ)			iber,
:	vithin 24 hours a within 24 hours a vithin 24 hours completely filled	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examina	wledge, deat tion and/or in	vestigation	, in my o _l	pinion, deat	d place, a h occurre	nd due to the d at the time	, date an	d place, an	d due to	the cause(s	;)
1		~	29b. Signature and title of certifier	1 Jack	A M	>		D61	768		1		e 11,			
			30. Name and address of person where Fabienne Santel,				•	oad,	Silve	er Sp	ring,	MD 2	20910			
	Sta		31. Date filed (Month, Day, Year)	2006 Regist	rar's Signa	ture	الكلية									

			. For	State of M	aryland / Dep		lealth and M	•	_	ibic.	
			1 - State Registrar			rtificate of l		-	Reg. No.	106	2016
	Physici	an	1. Decedent's Name (First, Middl		SENE	BONA	APEK	2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution				Location of Death	05	4c. Count	O6 V of Death	408
	Examin	er	Il uiposit	of War	uland	Baltimo			40. Count	y or Dealin	
	Funeral		5. Social Security Number		ge in yrs. last birthday			8. Date of Birt (Month, Da	th v Year	9. Birthpla	ace (State or Foreign
134	Director		321.40.6437 Usual Residence of Decedent	1⊠M 2□F	60 Yrs.	Working Buys	110010	Dec. 5	1945	Illir	nois
	/land		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Man a-f eh	tor	Maryland Montgo	mery	Silver	Spring					1 ☐ Yes 21X No
	ith the	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	e 23a	ral	1503 Milestone		5 110 110	20904			U.S.		
	Iter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces: ned 1 X Yes 2 □	No 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spi in, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - America ick, White, e	tc.
8	FEREN	by	3 Widowed 4 Divorced	If You Give	Vietnam	1 ☐ Yes 2)② No	Specify:		Specia	_{fy:} Whit	te
21215-0036	within 72 hours efter death with the Maryland ane. than "naturel", or iteme 23a or 28a-f ehow ha Mcdical Examiner must be notified at	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of E	Business/Ind	ustry
12	within ene. than	duic	Elementary/Secondary (0-12)	College (1-4or 2 Years	5+)	eneral Coi			Home	Bu i 1d:	ings
2	filed Hygi other	Be Co	17. Father's Name (First, Middle,			enerar con	18. Mother's Name	e (First, Middle,			
lar	should be nd Mental marked o	To B	Frank Bonarek				Jule 1	McIntyr	e		
Maryland	2 sho		19a. Informant's Name/Relations			ng Address (Street a					
_	of Health litem 27		Lucy Michiko I	Diby/Daughte	20b. Place of Disp	Wexhall		Burtons	ville,		
nor	Pages nent of ury or o		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cre	matory or other place coln Crem	(e) 06/12	/2006			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Marylan Department of Health and Mental Hygiene. mportant: If item 27 ie marked other than "nature!", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service			2. Name and Addres			brentwo	ood, M	aryland
ä	Per Per Per Per Per Per Per Per Per Per		Nanny A	. Verce	Ly I	INES-RINA 1800 New 1	LDI FUNER Hampshire	AL HOME Ave.Si	, INC. 1ver Sp	ring.	MD 20904
- 4			23a. Part1. Enter the dispase, or shock, or heart failure. List	complications that ceuse only one cause on each !	d the death. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
September 1	Physician		Immediate Cause (Final disease or condition resulting in death)	-a Mu	etyple 18	hunatic	lugures		/		Onset and Death
	/Medical Examiner		rosaning in doarn	Due to Or as	a consequênce of):	Kuck h	n acoto	r Vehi	cle		
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	000	1	-	VI) -		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S c							
8760,	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):			PI	Ind		
687	Attending Physicien: The law requires that the death certificate be executed roteth. octor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d							
Box (res that the death certifica igned by the attending pt be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7-			23d. Da	ite of deliver	у
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant a		⊒Ectopic pregnancy □ Other (s <i>pecify)</i>			Mo	onth [Day Year
P.O.	d by the	Phy	9 Unknown		M1 - 1 - M			00- 0111			
ds,	signe d be d	by	Part II. Other significant condition	ons contributing to death t	out not resulting in the t	inderlying cause give	en in Part I.		obacco use con ′es 2 □ No	tribute to the 3 ☐ Proba	cause of death?
Records,	w require	Completed						24a. Was			sy findings available
	sicien: The law certificate has b lirector, page 2 s	dwo						autop perfor	rmed?	prior to com death?	pletion of cause of
Division of Vital	Physicien: The lithis certificate har	BeC	25. Was case referred to medica				26. Place of Death		12	1 ☐ Yes 2	2∐ No
<u>></u>	Physic this ce al direc	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie		4 🗀 Nursing noi	me 5 ☐ Resid	lence 6 🗆 Oth	ner (Specify)	
uc	aling P	tlon:	27. Manner of Death 1 □Natural 5 □ Pendir	28a. Date of Inju (Month, Da	ly Year) Injury	P M 28c. Injury Work		28d. Describe h		1	14
/ISI	Attend death octor:	flcat	2 Accident investi 3 Suicide 6 Could 4 Hamiside determ	not be 28e. Place of In	jury - At home, farm, st		/-	Peacs 28f. Location (S	Street and Numb	STW0	
á	s after s after of in b	Certification:	4 Homicide determ	building, e	tc. (Specify)	, , , , , , , , , , , , , , , , , , ,		City or Tow	m. State) + CAton		BAItO
	To the Hospital or Attending i within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer		Check only 2 Medical	g Physician: To the best Examiner: On the basis of	of my knowledge, deal	h occurred at the tim	ne, date and place, a	and due to the o	ause(s) and ma	anner as sta	ted.
	thin 2 the I	Medical	one) 29b. Signature and title of certifie	and manner st	ated.						
	F 3 F 8		1 tems	W/Lung)	DO	061862		Tune	01, .	2006
7	10		30. Name and address of person	who completed cause of	death (Item 23a) (Type	Print)				,	-
	10 Miles	-	James (ushman	, MD 2	25. Gr	reeneS	+ Lal	to W	DZ1Z	102
	Sta Registr	3	31. Date filed (Month, Day, Year)	32 Registr	death (Item 23a) (Type, WD 2 ran's Signature	ente					
	- 150 YOK		0011 -	I STATE OF							

DHMH 17 Rev 1/2001

		ļ	For State Registrar	State o	f Mar	-	-	ment o			Mental Hy	/giene Reg. No.	2006	20161
	Physicia		1. Decedent's Name (First, Middle, La Donald Beaupre	st)							2. Date of D Month June 4	Day	Year	3. Time of Death 2:50 p M
•	/Medic Examin		4a. Facility Name (If not institution, giv Suburban Hospital	re street and nui	mber)			city, Tow		ocation of Dea		4c. (County of Death	
	Funeral Director			Sex 1□XM 2□F	7. Age ('In yrs. last bir		Under 1 You		f Under 24 Hrs Hours Min				place (State or Foreign
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is not proposed to the maryland and many injury or other traumatic event, the Medical Examinar must be notified at spice.	Direc	10a. State 10b. County Maryland Montgome 10e. Street and Number 5721 Grosvenor La: 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	12. Was Dece Armed Fo 1 EYes If Yes, Giv Year or D	edent Evrces? 2 □ Nove	16a.	13. Was If Ye 1 Decedent (Give kind life, DO)	20814 Decedent s, specify (Yes 22 s Usual Oct of work do NOT use re	of Hisp Cuban, No ccupation one dura atired)	Specify:	Specify Yes or Noto Rican, etc.)	Unit	en of What Cou ed Stat 4. Race - Ameri Black, White, Specify: Wh	es can Indian, etc. ite
and 21	ild be filed w lental Hygier ked other ti	0	17. Father's Name <i>(First, Middle, Last</i> Unknown			Mar	nagin	g Edi	18	3. Mother's Na nknown	me (First, Middle		nalism Sumame)	
Z .	and 2 shou ealth and M n 27 is mar	-	19a. Informant's Name/Relationship (Barbara Beaupre/S	Type, Print) Spouse		57	'21 G1	cosve	nor	Number or R	ural Route Numb Bethesda	er, City or	Town, State, Zip 20814	Code)
imore	Pages 1 ment of He lant: If Item jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)		20b. Place of cemeter Fort L	y, cremato incol	ry or other Ln Cre	<i>piace)</i> emat		Date 14-2006	Brent		Œ
T. C.	permit Depart Import any inj once.		21. Signard e of Fundral Service Licer 23a. Part1. Enter the disease, or com	L- Ma	ely								, 1040 F	Rockville
2 = 50 pm	ate be hysicie the bur	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c		L i				15 C. C		rca	Interval Between Onset and Death
4/9 BOR OG	The law requires that the death certification is a second of the law requires that the death certification is a second control of the law is a second contr	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 (ant at tim	pregnancy Fetal death ne ol death		opic pregna ner (specify				23	3d. Date ol delive Month	ery Day Year
DoNALD Vital Records P		Completed by PI	Part II. Other significant conditions of			not resulting in				in Part I.	1 ☐ 1 ☐ 24a. Was	Yes 2.2	No 3 ☐ Prob	ably 4 _Unknown
EAUPRE, DONA	ng Physician: fler this certifice meral director, p	Certification: To Be Com	25. Was case relerred to medical examiner? 1	28a. Date of (Monte)		- At home, lar	ime of njury	28c. li	Other: njury at Work? 1 Yes	4 Nursing H	1 Yes ath (Check only of dome 5 Resi 28d. Describe	orned? 2 No one) dence 6 how injury	death? 1 ☐ Yes ☐Other (Specify)
BEI	ne Hospita n 24 hours ne Funerel	edical	29a. Certifier Check only one) Certifying Ph	nysician: To the niner: On the ba and mann	ISIS OT 0X	amination and	, death occ	urred at the	e time, ny opini	date and place on, death occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)
	withii To the Comp	¥		mole,									signed (Month,	
			30. Name and address of person who Truong Bao, MD 97. 31. Date filed (Month, Day, Year)	15 Medic	a1 (Center	Drive	, Su	ite	201, R	ockville	, MD	20850	
	Stat Registra		JUN 13	2006	gistiar s	Signature	Appa	Car !						

		1 _ Stata	State of Mai	•	artment of F		nd Mental Hy	7111	06 20165
9 (8	, I	Registrar 1. Decedent's Name (First, Middle, Last)			Timouto or	Doutin	2. Date of De		3. Time of Death
Physici		William Overton H	Bowers				June	9 2	2006 10:00 A ^M
/Medi Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of	Death	4c. County	
		159 Sunbrook Lane	<u> </u>			gersto			hington County
Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age 5	(In yrs. last birthday) Yrs.	Months Days	Hours Hours	Min. (Month, Da	ly, Year)	Birthplace (State or Foreign Country)
Director		218-50-4514 Usual Residence of Decedent	J	0			April	1 1950	Maryland
yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
ith the Marylar or 28a-f show	cto	Maryland Washington	on	Hagerst					1X Yes 2 No
with th	Directo	10e. Street and Number			10f. Zip Code	24740		10g. Citizen of W	•
eath v	Funerai	1123 Moller Avenue	2. Was Decedent Ev	ver in ILS 13		21740	in? (Specify Yes or No	U.S.A	a - American Indian,
fter d	F	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No If Yes, Give	8-29-68			in? (Specify Yes or No Puerto Rican, etc.)	Black	k, White, etc.
el', o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	8-28-74	1 ☐ Yes 2 X No	Specify:		Specify.	: White
72 h 72 h	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup kind of work done	durina most o	of working	16b. Kind of Bu	siness/Industry
within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	oo not use retired uto Mecha	- /		Self	Employed
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. After than "naturel", or Items 23a or 28a-f show out, the Madrial Examinar munities mailing an		12 17. Father's Name (First, Middle, Last)		A	aco recila		's Name (First, Middle	-	
in year in Z I Z I 3-0030 thould be filed within 72 hours after death with Mental Hygiene. I marked other than "naturel", or Items 23a matic event, the Madical Examinar Tuni I	To Be	William H. Bower	S			E	Elwyn Overt	on Bower	rs .
0 0 5 00 3	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)
and 2 and 2 ealth a m 27 ls		Ellen Bertha Bower	s (wife)	·		Ave.	Hagerstown		
Deficiency into permit. Pages 1 and 2 Deperment of Health a timportant: If them 27 is eny injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	moval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location -	City or Town, State
mit. Pages pertment of portant: If it y injury or c.		4 Donation 5 Other (Specify)			urg Crema				sburg Maryland
permit. Depertrimports eny inju		21. Signature of Funeral Service Licenses	17,		2. Name and Addre		Dougras F		Funeral Home
		23a. Part 1. Enter the disease, or complic	ations that caused t	7					Maryland 21742 Approximate
Dhyafalan		shock, or hear failure. List only one Immediate Cause (Final	cause on each line			1	^		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	og Vasu	116	1) See		
Examiner		O	Hupiter	512-					> > 7,3
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence ol):					
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to los es e	consequence ol):					
of ou, ate be executed hysician and the burial-transit	al E		Due to (or as a	consequence or).					
The Colds, F.C. BOX 600. The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	edical	d.							
wrequires that the death certific been signed by the attending part about be detached for use as is should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of		75-44-4			23d. Date	e of delivery
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		□Ectopic pregnancy □ Other (specify) _	у		Mor	nth Day Year
at the	Phy	9 Unknown					oos Did		ib. A. to the course of death 2
ries th	þ	Part II. Dther significant conditions cont	nbuting to death but	not resulting in the L	inderlying cause giv	en in Parti.			ribute to the cause of death? 3 □ Probably 4 □ Inknown
w requires to been signed should be	eted	JIN SERVI	· .						
ne law ne law n has l	Completed	Chronic Lay 1	12502					psy primed2 d	Were autopsy lindings available prior to completion of cause of death?
VICIAN: The ician: The contificate sector, par	ပိ	25. Was case relerred to medical				26 Place	1 ☐ Yes		Yes 2 No
ysicia s cert direct	To B	examiner?	spital:	t 2 ER/Outpatie	nt 3 DOA Ott		sing Home 5 Resi		Mother-In-law's
ng Phy rer this		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	l 28c. Injui Woo			how injury occurre	POCIOONOO
VISION Attending or death. ector: Atte	Certification;	2 Accident investigation				Yes 2 □ N			
br Att	III	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (<i>Specify</i>)	reet, factory, office		28f. Location (City or To		er or Rural Route Number,
pltal		29a. Certifier 1 Certifying Physi	cien: To the heet of	my knowledge, desi	the accuracy at the to	ma data and	l place, and due to the	anusa(a) and ma	anar as stated
To the Hospital or Attending Physician: The lav within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai			examination and/or in			place, and due to the n occurred at the time,		and due to the cause(s)
To thi Mithin To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	i (Month, Day, Year)
)		> SAL M	10		0	0056	965	Jone	13,2006
		30. Name and address of person who con		ath (Item 23a) (Type	Print)			-	
3H9+1		25 E. Antist	Strelt	Hazers	town,	mo	21742		
St Regist	ate trar	31. Date liled (Month, Day, Year)	32. Registrar	W. D. D.	serlis				

			For State Registrar	State of Marylar	•	artment of H tificate of I			iene eg. No.200	6 20166
	. · ·		1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	th	3. Time of Death
	Physici /Medic		Helen Virginia	Barnes				June 1	$12^{ extstyle Day}, 2006^{ extstyle Ye}$	2:45 A ^M
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of D	eath
			Calvert Memorial				e Freder			t County
	Funeral		5. Social Security Number 6. So	7 M 2 X F	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,		Birthplace (State or Foreign Country)
	Director		364-22-6573 Usual Residence of Decedent	80				July 14	1925	Kansas
	yland		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	a-fst	ctor	MD Calvert	County	Owings					1 ☐ Yes 2 X No
	or 28	Jire	10e. Street and Number		0	10f. Zip Code		11	0g. Citizen of What	Country?
	ath w	rai	85 Grovefield La			2073			U.S.A.	
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No- to Rican, etc.)		rmerican Indian, /hite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	1	☐ Yes 2MNo	Specify:		Specify:	White
21215-003	within 72 hours after death with the Maryland sne. than "natural", or itams 23a or 28a-1 show he Mcdisal Examinar must be notified at	pel	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	ess/industry
215	hin 7; 9. Med	Completed	(Specify only highest gra-	College (1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most of wo d)	orking		
2	ad with	Con	12	3	Regi	stered N	urse		Hospit	al
nd	be filk d oth event	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M	,	
<u>\</u>	ould Men varke vatic	2	Horace Macferran					osephine		
Maryland	d 2 st th and 7 is m traum	1	19a. Informant's Name/Relationship (7) Eleanor J. Frankl		1	_		ural Route Number, Wings, Ma		
<u>ئ</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at anone.		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of			20c. Location - City	
more,	ages ant of t; If it		1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	emetery, cren ee Cren	natory`or other plac		e 13,		
altir	nit. Partme ortan injur	- 1	21. Signature of Fun						Home Ca	Maryland lvert, P.A.
ä	Dep Imp		Michael W. I	Que de la companya della companya della companya de la companya della companya de	81	.25 South	ern Mary	land Blvd	d., Owing	s, MD 20736
	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat	h. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	Firysician	(1 I)	Immediate Cause (Final disease or condition	Miss	Can	Sol a	Ento	C- 755m		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con *	uence of):		11/0	1,00		
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. =						
	pe:	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):			-4		
	axecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
8760,	icate be executed physician and s the burial-transit	edical		d.						
9			7.22.712							
Вох	Attanding Physician: The law requires that the death certific r death. actor: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of	,
Е	e dea the att	sici	in the past 12 months?	4□Pregnant at time of d		Other (specify)			Month	Day Year
P.O.	that the de led by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions or	patributing to death but not rec	ulting in the use	dochina couco au	on in Don't	22a Did tab	and the contribution	e to the cause of death?
Records,	signed of be der	by	Partit. Other significant conditions of	miniboting to death but not res	alting is the un	idenying cause give	en in Fait i.		s 2 No 3	
Ö	w requir been si should	etec						1		
Bec	has has	Completed						24a. Was ar autopsy perform	y prior ned? death	autopsy findings available to completion of cause of 1?
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				00 Plans of Da	1 Yes 2	1 □ Y	'es 2□ No
5	ysician: The is certificate his director, page	To Be	examiner?	Hospital: Linpatient 2	ER/Outpatient	t 3□ DOA Othe	D.F.	ath <i>(Check only one</i> Home 5 ☐ Resider		'ongifu'
0	g Physicar this leral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe ho		pacity)
0	ttanding I death. ctor: After y the funer	atio	Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □No			
Division of	or Atta	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or , State)	Rural Route Number,
	urs af urs af ural D	O								
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: Atter th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phi (Check only one) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death ition and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner ite and place, and c	as stated. fue to the cause(s)
	o tha o tha omple	Mec	29b. Signature and title of certifier	and mainer states.		29c. License	number	29	d. Date signed (Mo	onth, Day, (Year)
	⊢ s ⊢ ŏ			- m-)	DE	7014	9	6/1	2/01
			30. Name and address of person	completed cause of death (Item	л 23a) (Туре, F	Print	1-1-1-		0/1	706
	ID		David Gallata/ 1	o Hospital	Zd,	Prince	Fred	ent.	MS	
	€ Sta		31. Date filed (Month, Day, Year)	32. Registra s Signa	iture	1.4.	,			
	Registr	ar	JUN 1	4 2006 Bear	u St	Gosto	<u> </u>			

						epartment of			_	э.
			1 - State Registrar			Certificate of		Re	g. No.2 0 0	6 20167
	Physici /Medi	cal	Decedent's Name (First, Middle, Las Joseph Frank Bla 4a. Facility Name (If not institution, give	gus		Ab Ciby Tourn	or Location of Dea	2. Date of Death Nonth	Day 200	
*	Examir	ier	1 4 4 / 0 /	RSING 1	Home	SALIS	BURY	ıtn	4c. County of D	
	Funeral Director		148-03-9038	9x 7. Ag	ge (In yrs. last birtho 91 Yr	Months David			9. ,1914 N	Birthplace (State or Foreign Country) ew Jersey
Ç	yland how		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
3	Ba-1s	Director	Maryland Wicomico		Parsons					1 ☐ Yes 2X No
7	death with the Maryland ms 23e or 28a-f show rmust be notified at	Dir	10e. Street and Number 32248 Long Ridge 1	Road		10f. Zip Code 2184		10	g. Citizen of What US	•
-3	r death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cu		Specify Yes or No-	14. Race - A	merican Indian, /hite, etc.
36	urs afte	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	1945	1 ☐ Yes 2 🗓 No			Specify:	White
2-0	within 72 hours after ene. then "natural", or Ite	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. D	ecedent's Usual Occu	upation e durina most of wa	orkina 1	6b. Kind of Busine	
121	within iene. then	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	e. <i>DO NOT use retir</i> Farmer	ed)	9	Poultry	•
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan id Mental Hygiene marked other then "natural", or ltems 23e or 28e-1 show matic event, the Medical Evantinar must be notified at	Be C	17. Father's Name (First, Middle, Last)			urmer		me (First, Middle, M	aiden Sumame)	
ry Ia	hould be to demand the marked of matic eve	ပ	Andrew Blagus 19a. Informant's Name/Relationship (T	ino Brint	105.14	-10		Maiden Su		
	permit. Pages 1 and 2 should b Department of Health and Mente Importent: If item 27 is marked any injury or other treumatic a <u>pnce</u> .		Dianne Day/Daughte			ailing Address (Stree 48 Long Ri				e, Zip Code) ryland 21849
ore,	ges 1 st of He If item or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	ace)		Oc. Location - City	
Baltimore,	nit. Pa artmen ortent: injury injury B.		' 4 □ Donation 5 □ Other (Sp City) 21. Signature of Funeral Service License	See O 2		Memorial Pa		/2006 Sa	alisbury	Maryland
Ba	permi Depar Impo any ir		Heneue a	J. Sell	w	22 Name and Addr Zeller Fun 1212 Old C	eral Home	P. O. H	Box 3171	MD 21802
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lication that caused ine cause on each li	the death. Do not	enter the mode of dy	ring, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	ROTOR	DISEAS			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sick Due to (or as	a consequence of):	SYNDRO	ME.			
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
/60	m > 0	caiE	l	d						
X 68	death certificate b attending physic for use as the b	Medi	IF FEMALE:							
O. Box	requires that the death certifica leen signed by the attending ph hould be detached for use as th	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes V☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	су		23d. Date of d Month	delivery Day Year
rds, P	w requires that the debeen signed by the should be detached	ed by P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in th	e underlying cause gi	ven in Part I.			to the cause of death?
	The law ate has b page 2 s	Complet	•					24a. Was an autopsy performe	prior t death	autopsy findings available o completion of cause of ?
VITAI	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	h	ath (Check only one)		
on or	Phy this ral d	tion: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		of 28c. Inju	Nursing F	ome 5 ☐ Resident 28d. Describe how		pecify)
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or (State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai (29a. Certifier (Check only one) (Check only one) (Check only one)	sicien: To the best of ner: On the basis of and manner sta	examination and/or	eath occurred at the ti investigation, in my o	ime, date and place opinion, death occu	, and due to the caustred at the time, date	se(s) and manner and place, and di	as stated. Le to the cause(s)
	To t Comp	Ž	29b. Signature and title of certifier	0		29c. Licens			Date signed (Mon	nth, Day, Year)
			30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Tvo	ne, Print)	063199,	6	12 06,	
			YOGESH VOHR	A, MD	614 EA	STERNSHI	RE DR.	, SALIS	, MD.	21804
	Sta Registra		31 Date filed (Month, Day, Year) JUN 14	2006 32. Registra	ar's Signature	STELNSHI				

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			1 - For State Registrar	State o	f Marylai		artment of l rtificate of		Mental Hy	giene Reg. No. 🥠 (000	0016
\$	Physici /Medic		Decedent's Name (First, Middle, L		Paul Been	nan			2. Date of De Month June	e 15, 2006	Year	3. Time of Death O
	Examin		4a. Facility Name (If not institution, g				4b. City, Town,	or Location of De		4c. County		
Ş				Pershing S	7. Age (In yrs	(ast birthday)	If Under 1 Year			th	Alleg	any lace (State or Foreign
	Funeral Director		216-76-8188	10 X M 2□ F	48	Yrs.	Months Days	Hours M	in. (Month, Da August 1	y, Year)	Cour	laryland
	D >		Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Lo	action				1	Od. Inside City Limits
	/acyla	ō		egany	100.0	ity, TOWITO, LO		Lonaconing	r			1 Yes 2 □ No
	1 the h	Director	10e. Street and Number				10f. Zip Code		,	10g. Citizen of W	Vhat Coun	itry?
	15 with with 23 a o	aiD	100 Wes	t Main Stre	et			21539		United S	tates of	f America
9	be filed within 72 hours after death with the Maryland Hygiene. d other than "neturel", or items 23a or 28a-f show event, the Medical Examiner must be multilised at	by Funerai	11. Marital Status 1 □ Never Married 2 Married	Armed Fo	2∭No ve		Was Decedent of f Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	- 14. Race Blac Specify	k, White,	an Indian, etc. White
5-003b	hours turel'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or D	ates:	16a Dece	dent's Usual Occu	pation		16b. Kind of Bu	siness/Inc	
<u>ر</u> ب	be filed within 72 ital Hygiene. d other then "nelevent, itte Medic	Completed	(Specify only highest g	rade completed)	1-40r 5+\	(Give	kind of work done DO NOT use retire	during most of wad)				·
7	filed withi Hygiene. other ther	Com	Elementary/Secondary (0-12)	College (Re-l	Pro Worker				ity Agency
and		To Be	17. Father's Name (First, Middle, Las	Paul Been	nan			18. Mother's N	lame <i>(First, Middl</i> e, A 1	Maiden Sumam rlene Bean	e)	
Mary	d 2 should by th and Menta 7 is marked traumatic ev	_	19a. Informant's Name/Relationship Rebecca Jane Be		'n	19b. Mailir			Rural Route Number			
_	Heal Heal ther		20a. Method of Disposition			Place of Dispo	sition (Name of	i iviaiii Suc	Date	20c. Location -		
altımore,			1 ABurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State		natory or other pla Hill Cemeter		June 20, 2006		_	Maryland
Balt	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lic	ensee '		22			AcKenzie Fur eet, Lonaconi			539
Ξ			23a. Pari1. Enter the disease, or co srigck, or heart failure. List on	y one cause on e	each line.			-				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Mej	tusta	tic c	ance/	of 7	heurin	ary blue	der	Onset and Death
	/Medical Examiner		A South of the sou		(or as a conse							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conse	quence of):						
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/89	ficate g phys	edicai		d								
ROX	death certifi e attending p ed for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregr		Ectopic pregnanc	·v			e of delive	•
D D	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (specify)			Mor	nth	Day Year
٦.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contr	ibute to th	e cause of death?
rds	w requires been sign should be	ed by	Urinary	Tract	inte	ction			101	res 28No	3 🗆 Prob	ably 4 Unknown
Records,	law re as bee 2 sho	Completed							24a. Was	an 24b. V	Vere autop	psy findings available inpletion of cause of
Ĭ	The ate h page	Com							perfo 1□ Yes	rmed? d	leath?	
Vital	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			- 0:		eath (Check only o		i	tone of
Division of	ng P After t Anera	tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Mon		28b. Time of Injury	28c. Inju	ry at ork? Yes 2 No	9 Home 5 ☐ Resident Particles 1	dence 6 A Other	ar <i>(Specif</i> y ad	Relative
NINE	I or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place	of Injury - At I	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the b	best of my kn asis of examin	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and mai date and place, a	nner as stand due to	ated. the cause(s)
	To the within To the zomple	Med	29b. Signature and little of certifier	/			29c. Licen	se number		29d. Date signed	l (Month, L	Day, Year)
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			30. Name and address of person wh	Name of		60	1.0					
300	Section - Co		31. Date filed (Month, Day, Year)	De VIIN	20 J	Dong Ins	Avenue	Lenn	coning,	ma)		
2.	Sta Registi		JUN 2 0	2006	gistrar s orgi	AT A	630/6 N					

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			ene g. No. 2006	20169
	Physici /Medic		1. Decedent's Name (First, Middle, Last	•	Bison			2. Date of Death Month	Day Year	3. Time of Death
	Examin	1.0	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	ith
	=	Ţ.	Garrett County Men	morial Hos	spital	0.	kland		Garre	tt
	Funeral		5. Social Security Number 6. Se.	x 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		216-22-6122	□M 2X)F	78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2/1/192	28 M	ountry) ary Land
	P.		Usual Residence of Decedent		1					
	show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f	cto	MD Garre	ett			Oakland	1		1 ☐ Yes 2 💢 No
	ith it	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	ath w 23a	rai	88 Knoll Crest He				550		USA	
	r deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2 21	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi	
36	or li	by Fu	1 Never Married 2 Married	If Yes, Give	No	1 ☐ Yes 2 📉 No	Specify:			White
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinet must be multied at		3 Widowed 4 Divorced	Year or Dates:	1 10 0					
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup s kind of work done of DO NOT use retired	during most of wor	king 1	6b. Kind of Business	Vindustry
12	within ene. than "	g.	Elementary/Secondary (0-12)	College (1-4or 5	5+)	eller	"		Bank	
2	be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "natural", or Items 23s or 28s-f show event, the Medical Examiner must be rutilised at		17. Father's Name (First, Middle, Last)			CIICI	18. Mother's Nam	ne (First, Middle, M		ET
an	od o	Be	Robert	WINTER	RS		Haze1		Fresl	-
Ξ	2 should be and Mental is marked craumatic ever	ဥ	19a. Informant's Name/Relationship (Ty			ing Address (Street		ra / Route Number	City or Town, State,	-
Maryland 21215-0036			Doyle E. Biser/ Hu							,
	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition	usband	20b. Place of Disp	osition (Name of			kland, MD Oc. Location - City or	
وّ	Pages 1 and ment of Health tant: If item 27 jury or other t		1X Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or other plac		-		
Baltimore,		174	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Inerall \$ervica All his			Co. Mem. (Oakland, N	
Bal	Depariment of the police of th		21. Signature of America Association			2. Name and Addres	•		Funeral Ho	ome
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		1. Decedent's Name (First, Middle,	Last)						2.	Date of	Death			3. Time of Death
Physic /Medi		John Wilbert Ber	e III						J	Month une		^{Day} 2006	Year	1:40 A M
Exami		4a. Facility Name (If not institution,		umber)		4b. City,	Town, or	Location o					y of Death	11-10 11
		Casey House				Rock	vill	e			M	ontg	omery	
Funeral	1		S. Sex	7. Age (In yrs.	last birthday		1 Year Days	If Under 2	24 Hrs. 8. Min.	Date of I			9. Birtho	place (State or Foreign
Director		218-22-6430	1 X) M 2□ F		79 Yrs.	Months	Days	Hours		lay 1		927	Mary	
2		Usual Residence of Decedent		1400										
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6 8a-f	ctc	Maryland Montgom	ery	Sil	Lver Sp									1 Yes 2th No
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s att	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive 1945-	-47	1□ Yes 2	X No	Specify:					whit	
hours a			Year or	Dates:	1 10 0									
n 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual kind of won DO NOT us	k done du	tion <i>uring</i> most	of working		16b.	Kind of B	lusiness/In	dustry
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Hygin Hygin	ပိ	17. Father's Name (First, Middle, La	ist)		ореге	.c.rono			r's Name (F	irst Mida				Crimene
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d Median	J	19a. Informant's Name/Relationship			19b Maili	ng Address	(Street or	nd Number	s os Pusol O	louis Alum	has Cit	T	C4+4- 7:-	0-4-1
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sermit. Pages Separtment of mportant: if i iny injury or o		21. Signature of Funeral Service Li	ensee	11	G_{c}^{2}	ing H	ome	Crema	tion	Serv	ice	P.O	• Box	784
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(cate be executed / Medical Examiner / Medical Examiner buvial-Itanslt the buvial-Itanslt	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	or as a consection as a consection of the consec	quence of):									Onset and Death
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ilcian: Th certiticate rector, pag	Ö	25. Was case referred to medical								1 Yes	2 X N	0 1	1 🗌 Yes	2 No
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To the Hospital or Attendi within 24 hours atter death. To the Funeral Director: A completely tilled in by the fu	edical (29a. Certifier 1	Physicien: To th aminer: On the b and mar	e best of my kno pasis of examina nner stated.	owledge, death ation and/or in	n occurred a vestigation, i	t the time in my opir	, date and nion, death	place, and n occurred a	due to the	cause(s	s) and ma	inner as sta and due to	ated. the cause(s)
To th	Me	29b. Signature and title of certifier				29c.	License r	number			29d. Da	ate signed	d (Month, E	Day, Year)
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7.		30. Name and address of pirson wh	completed cou	se of death /lton	n 23a) (Tuno					ŀ				
10		Joseph Kaplan, M	D. 600	Muncas	ster Mi	.11 Ro	ad Ro	ockvi	.11e,	MD 20	0855			
Sta	ate	31. Date filed (Month, Day, Year)	32.	strar's Signa	iture						7.5		ATTENDED IN	
Regist		JUN 1 4	2006	Robert		Card 1								

State of Maryland / Department of Health and Mental Hygiene? [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2006 June 10, 11:59P M William Henry Boesche /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6832 Mink Hollow Road Howard Highland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 F Yrs. Director 1964 Pennsylvania 217-92-1178 41 10. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2X No Directo Maryland Howard <u>Highland</u> 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6832 Mink Hollow Road 20777 USA Funeral 12. Was Decedenl Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Mariella William Henry Boesche Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Boudrye/wife 6832 Mink Hollow Road Highland, MD 20777 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 XCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 06/14/06 Beltsville, MD 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lateral sclerosis **Physician** /Medical Examiner Sugar kially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) cete hes been signed by the page 2 should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 (ZNo 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 3 DOA 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Xetural 5 Pending 1 Yes 2 No death. М investigation 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifie June 12, 2006 who completed cause of death (Item 23a) (Type, Print) 1. Charles St. Bolt, Md 2124 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND # 23ac PER PHY 6-1506 CCHD DB Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Jumenth 12,2006 **Physician** 12:00pm M Dorothy Gray Barnhart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Civista Medical Center LaP1ata Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🗙 F Yrs. 577-09-0780 90 1915 Maryland 1, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or itame 23a or 28a-f ahow other traumatic avent, the Madical Examiner must be notified at 1 ☐ Yes XX No Directo Maryland Charles Brandywine 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16018 Meandering Drive 20613 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2X No Specify: Be Completed by 3X Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical House of Representative 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be filt partment of Health and Mental Hy portant: If item 27 ts marked oth y injury or other traumatic aven Mamie Elizabeth Essig John Rubin Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna E. Heiston - Daughter 16018 Meandering Drive, Brandywine, MD 20613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington National 6-16-06 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Depart Import any inj 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01391 POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as consequence of): Examiner Ch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ysician and e burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a Records, P.O. Box 68760 Completed by Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use cooribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No 1 Yes Division of Vital After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. after death Diractor: / d in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funerail 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37174

State Registrar 31. Date filed (Month, Day, Year)

Darnhar

DHMH 17 Rev 1/2001

Song C. Chon, MD, Cenna Medical Center, 7C Post Office Rd., Waldorf, MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 5 2006

32. Registrar's Signature

			_ For	State	of Mary	land / De	partmer					ygiene	2000	20172
			- State Registrar			С	ertificat	e of L	Death			Reg. No.	2000	20113
	Physicia		Decedent's Name (First, Midd	fle, Last)							Date of D Month	eath Day	Year	3. Time of Death
	/Medic	al	Catherine McB1 4a. Facility Name (If not institution				4h City	Town or	Location o		June	6	2006 County of Dea	7:30 P M
100	Examin	er									-			
.,	Funeral	4150	Montgomery Vil 5. Social Security Number	6. Sex	7. Age (In	re Ctr. yrs. last birthd	MONE Months		ry Vi If Under: Hours	24 Hrs. Min.	8. Date of B (Month, L	irth	Montgor 9. Bird	thplace (State or Foreign
Ė	Director		041-22-2294	1 □ M 2 🙀 F		78 Yrs	NOTION	Days	Hours		July 2			necticut
	and ow		Usual Residence of Decedent 10a. State 10b. Count	у	10	c. City, Town or	Location							10d. Inside City Limits
	Mary Ind	tor	Maryland Princ	e George	's	Laurel								1 ☐ Yes 21 No
	th the	Director	10e. Street and Number	o occipe			10f. Zip	Code				10g. Citi	zen of What Co	ountry?
	ath wi	rai	15607 Bounds A						20707				USA	
	lterne Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	Armed	ecedent Ever Forces? s 2⊠No	r in U.S.	3. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori in, Mexican	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race - Ame Black, Whit	
920	urs af	by	3 ⚠Widowed 4 □Divorce	If Yes,			1 ☐ Yes	2 ₩ No	Specify:				Specify:	Thite
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0	filed v Hygie other I	e Co	17. Father's Name (First, Middle	, Last)		Nur	se		18. Mothe	r's Name	(First, Middl		Sumame)	
an	fental fental rked tic ev	To B	Thomas Henry M	CBrien,	Jr.				Cat	heri	ne	Botti	celli	
Maryland	and Name		19a. Informant's Name/Relation			19b. M	ailing Address	s (Street a	and Numbe	er or Rura	Route Num	ber, City o	r Town, State,	Zip Code)
45	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23s or 28s-f show region traumatic event, the Marked Examiner must be mailfied at		Brien T. Beran	d	Son	156 20b. Place of Di	07 Bou		Avenu		urel,		and 20	
Baltimore,	T S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		m State	metropo	rematory or d Litan	me or other plac	(e)	D	ate	20c. Lo	cation - City or	Town, State
Eir	nit. Pa artmer ortant injury		4 □ Donation 5 □ Other (21. Signature of Poneral Service			-		ator	$\mathbf{y} = \mathbf{J}$		12,200	6 Ale	xandria	,Virginia
Ba	permit. Pages 1 Department of H Important: If Ite any injury pr off		1 Kohist	Ekan		7	Franci	s J.	Co11	ins 1	Tunera	1 Hom	e, Inc.	MD 20901
Est.	- 1 5		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications the	at caused the								Opxre	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Dehy	dratio	n								Onset and Death 3 weeks
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dec	* 4.4	er	S quentially list conditions if any, leading to immediate			arction ensequence of):	Dement	tia						
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C Diab	etes									
760,	be executed sicien and burial-transit	I Exa	resulting in death) Last			onsequence of):								
6876	⊕ × ⊕	dical		d										
9 xc	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of p	regnancy							23d. Date of de	liverv
. Box	death e atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No		e birth 2 [egnant at time		3 □Ectopic p 5 □ Other (s)		·				Month	Day Year
P.0	at the d by th etache	Phys	9 Unknown								00 · Did			
	es ped	þ	Part II. Other significant condi	tions contributing to	death but no	ot resulting in th	e underlying (cause give	en in Part I.			tobacco u		o the cause of death?
Records,	w requir	Completed									24a. Wa		·•	utopsy findings available
Re	The lav	дшс									aut	opsy formed?	prior to death?	completion of cause of
Vital		0	25. Was case referred to medic	al					26. Place	of Death	(Check only	2 🔀 No	1 L Yes	2 No
of V	ys S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	☐ Inpatient	2 ER/Outpa	tient 3 D	OA Oth	er: 4 🕱 Nu	irsing Hon	ne 5 Re	sidence (6 □Other (Spe	cify)
o uc		ion:	27. Manner of Death 1 Natural 5 Pend	ling (N	ite of Injury Ionth, Day Ye	28b. Tim Intu	У	28c. Injun Worl	k?		8d. Describe	how intur	y occurred	
Division	or Attending after death. Director: Aftel in by the fune	ertification:	3 Suicide 6 □Coule	d not be 28e Pl	ace of Injury	At home, farm	M street factor		Yes 2 □I		8f. Location	(Street an	d Number or Ri	ural Route Number,
<u>S</u>	al or A after I Dire	Certi	4 Homicide deter	mined 289. Pi	ilding, etc. (S	Specify)	31.001, 12001	y, o			City or T	own, State)	
	To the Hospital or Attenwithin 24 hours after deall To the Funaral Director: completely filled in by the	edical ((Check only 2 Medica	ring Physicien: To al Exeminer: On th	e basis of exa	amination and/o	eath occurred r investigation	at the tin	ne, date an pinion, dea	d place, a	nd due to the	e cause(s) e, date and	and manner as place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certif		anner stated		29	c. Licens	e number			29d. Dat	e signed (Mont	h. Day, Year)
	- s - 8		> Inlead	2 Mes	nucle	in		J	192	94		Ju	INE 7	, 2006
	V		//	n who completed c	ause of death	n (Item 23a) (Ty	pe Print)	/ John	R. Me	Inje		020		, 1
-	5 to b 1 1 to		31. Date filed (Month, Day, Yea	hise(/	/ Pagistrar's	Signature	hereb	my,	11	d.	20	1//		
4	Sta Registi		JUN 1 2	2006	Systes	Signature	ack							

			For State Registrar	of Maryland / [Certificate			Reg. No.	Ub 201/4
	D.		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day	3. Time of Death
	Physic /Med		VERONICA SARAH GRAY BLA				JUNE	11, 200	
	Exami	iner	4a. Facility Name (If not institution, give street and			vn, or Location of Death		4c. County	
		. 3	CIVISTA MEDICAL CENTE 5. Social Security Number 6. Sex	7. Age (In yrs. last bii		LATA Year II Under 24 Hrs.	8. Date of Birt	CHAR	9. Birthplace (State or Foreign
K	Funeral Director	_	220–28–6103 ^{1□ M 2} 🛣		Yrs. Months D	ays Hours Min.	JANUARY 9	v. Year)	MARYLAND
AIK			Usual Residence of Decedent	10c. City, Tow	- or location				10d. Inside City Limits
1	lanylar ehow	5	10a. State 10b. County						1 Yes 2 No
W	the M. 28e-f	ecto	MARYLAND CHARLES 10e. Street and Number	PURI I	OBACCO	de		10g. Citizen of \	
,	th with	٥	9120 POOR HOUSE ROAD		206			UNITED	
١٨.		Funeral Director	11 Marital Status 12 Was I	Decedent Ever in U.S.	13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-		ce - American Indian, ck, White, etc.
V)	after or its	/Fu	If Yes	d Forces? ′es 2 DANo c, Give	1 Yes 2	_	7 (10411, 5(0.)	Specif	
	15-0036 72 hours after des "natural", or Home	d by		or Dates:	a. Decedent's Usual O	lecupation			y: BLACK
T	2 12	olete	15. Decedent's Education (Specify only highest grade completed)	(ed)	(Give kind of work of life. DO NOT use r	form during most of work	ang	TOD. KING OF B	usiness industry
()	21215-0036 ad within 72 hours af gliene. er then "natural", or t, the Medical Exam	Completed	8TH GRADE Collect	ge (1-4or 5+)	DOMESTIC			PRIVA	ATE
~	re, Maryland 2121 s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 Is marked other then other treumatic event, Item Ma	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam			
7	Maryland id 2 should be file th and Mental Hy 27 is marked oth treumatic event	To	JOHN ARCHIE GRAY			ELLA LOU			
RON	Aar 2 sh and and 1s m		19a. Informant's Name/Relationship (Type, Print)			treet and Number or Rui			
X	ore, M		JO ANN JAMIESON / DAUGI 20a. Method of Disposition	20b. Place of	Disposition (Name)	OUSE ROAD,	Date Date		1ARYLAND 20677 - City or Town, State
W	A 0 0 .		1 Burial 2X Cremation 3 Removal for		NTT CREMA		14 2006		, MARYLAND
7	Baltimore, permit. Pages 1 ar Department of Hea Importent: if item any injury or otheren.		4 □Donation 5 □ Other (Specify) 21. Stonature of Funeral Service (Jeensee	9.0					, IMMILIME
	B e de in e		LYDIA C. THORNION JOHNSO	N M00583	THORNTON	ddress of Facility I FUNERAL HO JINGSTON RO	ME, P.A AD TNDTA	N HEAD	MARYLAND 20640
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	Physician	1	Immediate Cause (Final disease or condition	pulmo	nary	Eden	0		Onset and Death
	/Medica Examine		resulting in death)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Maurice Р. Courbat June 3, 2006 7:43 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 X M 2 □ F Yrs 579-03-1001 1919 Washington, 86 20, **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or items 23a or 28e-f ehow 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then any finiury or other traumatic event, the Magnetic Pages. Elementary/Secondary (0-12) Coltege (1-4or 5+) 4 Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Courbat Nora Tierney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corine Cockrell/Personal Rep. 7501 Wisconsin Avenue, Pethesda, MD 20814 of Discosition /Name of Date 20c. Location - City or Town 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State June 12, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2₽ No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 12 Naturat 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D43378 June 3, 2006 person who completed cause of death (Item 23a) (Type, Print) dress of Karen Merritt, 3110 Gracefield Road, Silver Spring, MD 20904 M.D. 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JUN. 5000 Registrar

		-	For State Registrar	State of	Maryland		artmen rtificat					giene Reg. No.	200	6	20176
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Funeral Director		5. Social Security Number 1.8. Sex 7. Age (In yrs. last birthday) 1.4. Months Days Hours Min. 2.5. Social Security Number 1.8. Sex 1.8. Months Days Hours Min. 7. Age (In yrs. last birthday) 1.5. Months Days Hours Min. 7. Months Days Min. 7. Months Days Min.	Date of Birth (Month, Pay Yea 7/30/1924	9. Birthr	alace (State or Foreign httry) MD							
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physical and	- OA VAL		30. Name and address of perso, who completed cause of death	Item 23a) (Type	e, Print)		Λ.	-		- 20	#ED		
3	T 6+1		LUCY VAN VOORHEE	5 3	14 1	PANKLI	AHU)E	83	LIN.	VIII		
		ate	31. Date filed (Month, Day, Year) JUN 1 4 2006 32. Fegistrar's S	ignature/	brode					i	1		
	Regist	uel.	JUN 1000 12 2000										

Raymond Richard Carbaugh 1- For State

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 2017

Registrar Certificate of Death									Reg. No. 2. Date of Death 3. Time of Death				
h Physiciar Međical Examin	er	Raymond Richard Carbaugh									Day Year 2006		3. Time of Death 1621 hrs
		Facility Name (if not institution, give street and number) Monroe Avenue						tb. City, Town, or Location of Death Frederick 4c. County of Death Frederick					
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$								Foreign	nplace (State or note Maryland		
f faryland 28a-f show any 1 at once,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick									10d. Inside City Limits 1 X Yes 2 No		
the Mary is or 28a- utified at	<u> </u>	10e. Street and Nur 201	Monroe	Avenue	е			10f. Zip Code 2170	01		10g. Citizen of Wh. U.S.A		try?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Fune	3 X Widowed 4 Divorced in res, Give Year 1947 1949 1 Yes 2 X No specify: Specify: Specify:								White Specify:	ace - American Indian, Black, /hite, etc. ify: White f Business/Industry		
C1 3 🗔 7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Ground Maintenance County Go											
21215-0036 sold be filed within 7 Mental Hygiene. marked other than c event, the Medica	<u>8</u>	Melvin Augustus Carbaugh Emma Gertrude Ebberts											
sho and and and and	_[19a. Informant's Na Nevin E.	Cramp				19b. Mailing 13104	Address (Stre Old Anr	et and Number napolis	or Rural Route Nu Road, Mt	mber, City or Town	State, MD 2	Zip Code) 21771
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other transmatte.		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery 20c. Location - City or Town, State Frederick, MD											
		21. Signature of Fu	38-	Dro	1	MO025	5 10	6 East	Church	ford PA F St., Fre	derick,	MD 2	21701
Physician /Medical 5xaminer		23a. Part I. Enter th failure. List on Immediate Cause (ly one cause	on each line.	that caused trail Gunsho			e mode of dying	g, such as cardia	ac or respiratory an	rest, shock, or hea	rt	Approximate Interval Between Onset and Death
France College Classes Wilde		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.											
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated											
W = 0 %	- 6	events resulting in death) Last Due to (or as a consequence of): d.											
760, cate be execut physician and the burial - trai	<u> </u>	UNPENDED											
6876 certificat nding physes as the	au	IF FEMALE: 23b. Was decedent past 12 months	?	1 4 4 L	If yes, outcom Live birth Pregnant at t	-	2 Feta	al death 3 er (Specify)	Ectopic pre	egnancy	23d. Date of o	lelivery Da	ay Year
O. B at the de de de de de de de de de de de de de		Part II. Other signi	ficant condit		,	but not resu	ılting in the un	derlying cause	given in Part I.	23e Did t	obacco use contrib	ute to th	ne cause of death?
cords, P.O.	ted by									1 Ye			bly 4 Unknown
ion of Vital Records, P.O. Box rending Physician: The law requires that the death auth. or: After this certificate has been signed by the auther function, page 2 should be detached for ut	Completed									auto	osy pr ormed? de		mpletion of cause of
Vital Recysician: The I his certificate I director, page	a Re	25. Was case reference examiner?	red to medica			-		26 Plac	e of Death (Che				
FVit	٥L	1 🗸 Yes	2 No	Hospital:	III III patiei		R/Outpatient				Residence 6	,	Scene
Division of tall or Attending Phara flet death. The Theretor: After tall Director: After tall or by the funeral	Certification:	27. Manner of Deat 1 Natural 2 Accident	5 Pend	ling FC	Date of Injur (Month, Day,Ye DUND: n 19, 2006	ar) F 1	8b. Time of Inj OUND: 616 hrs	1	ury at Work? Yes 2 ✓ No	Subject sho			
Division To the Hospital or Attend within 24 hours after death to the Funeral Director. completely filled in by the		Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	Medical			miner: On the						and due to the caused at the time, date			
F 3 F 8	Ĭ	29b. Signature and	title of certifie		11	/		29c. Licen			June 20, 20		h, Day,Year)
30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 25								21201	Julie 20, 200		·		
State 31. Date filed (Month, Day, Year) 32. Constraints Signature													
Registr	_	J	UNZ7	2006	A. Barre	J. J.S.	April			····			
OCME 2006	JT					(ORIGINAL						

			For State	State of	f Maryl		•	ment of H			ental H		2006	20180		
			1 - State Registrer Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death									000	3. Time of Death			
	Physicia		,		Almed	ia Cro	.70				June Month	1		0235 A M		
	/Medic Examin												c. County of Death			
		•	Laurelwood Ca	1				Ceci1								
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F		Under 1 Year onths Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, L	Birth Day Year	9. Birth	nplace (State or Foreign untry)				
	Director	Director 222–18–77/4 81						Sinis Buyo	110010					rginia		
	and		Usual Residence of Decedent 10a. State 10b. County		10c	City, Town or	r Locatio	on	•					10d. Inside City Limits		
.UU36 hours after death with the Manyland	Manyl f sho	ō	Maryland Ceci	1		E1kton								1 X Yes 2 □ No		
	28a	Director	10e. Street and Number				1	Of. Zip Code				10g. C	itizen of What Cou	intry?		
	h with		125 South Tar	tan Drive	2			21921				Uı	nited Sta	ates		
	deat	Funeral	11. Marital Status	12. Was Dec		n U.S. 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R					cify Yes or N	10-	14. Race - American Indian, Black, White, etc.			
8	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or itame 23a or 28a-f show event, the Medical Examinar must be exhitted at	y Fu	1 Never Married 2 Marri	2XINo ve	1 ☐ Yes 2 🏋 No Specify:					riiouri, oto.,		Specify: Wh:				
215-0036	hours tural',	d by	3 ₩ Widowed 4 □ Divorced	3 N Widowed 4 Divorced Year or Dates: 15. Decedent's Education					-							
ò	within 72 ene. than "nai	Completed	(Specify only highes	(G	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry					
7 7	with liene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker							In Her Own Home						
9	e filed at Hygie other vent, th	Be C	17. Father's Name (First, Middle, Last) 18. Mother					er's Name	(First, Midd							
yland	ss 1 end 2 should be of Health and Mental litem 27 is marked or other treumatic even	ToE	James Braxton McCreary Claudia							a Johnson						
Mar	and and is my		19a. Informant's Name/Relationsh									lumber, City or Town, State, Zip Code)				
	end lealth m 27 her tr		Brenda Anne Kra	utter/Dau									Maryland			
Baitimore,	ges 1 if ite or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 Removal from	State			n (Name of ry or other place	, -	lune	24,	20c. l	Location - City or T	own, State		
	t. Pa rtmer rtent: njury		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I					metery		2006			ion, Mary	land		
g	permit. Pages Depertment of I importent: if It any injury or o		21. Signature of Pulleral Service	Q	1	. 1	Hic	me and Addres	for	Fune	rals,	P.A.	Ma1	1 01001		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate		
	Physician :		Immediate Cause (Final	only one cause on o	each line.		2.2							Interval Between Onset and Death		
	/Medical	iner	disease or condition resulting in death)	aDue to	(or as a con	sequence of):	150									
	Examiner		Sequentially list conditions, b. 144 by the conditions													
<u>, </u>	D #		if any leading to immediate Due to the a consequence of):													
/	ecute and I-tran	Examine								_						
8/60	icate be executed physician and the burial-transit	alE	Alzhours dee													
200		edical		0.												
X P P	death certific e attending p d for use as	M/n	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d. Date of delivery					
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								Month Day Year				
л О	at the de d by the a etached t	Phy	Part it. Other significant conditions contributing to dealir but not resulting in the underlying cause given in Part i.													
က်	ires that signed to I be deta	by										bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown				
ecords,	w require been sign	etec											- 12-140 3 1-10			
Ž	eician: The law requires that the certificate has been signed by th irector, page 2 should be detach	Completed									24a. Wa aut	is an opsy formed?		opsy findings available ompletion of cause of		
Vital		e Co									1 ☐ Yes	25 No 1 ☐ Yes 2 ☐ No				
	yaicia is cart direct	o B	examiner?	Hospital:	Inpatient	2 ☐ ER/Outpa	tient 3	DOA Othe					6 □Other (Speci	(64)		
0	ding Phye h. After this funeral di	n; T	27. Manner of Death	28a. Date	of Injury th, Day Yea		e of	28c. Injury Work			28d. Describe			(9)		
Š	ttendin death. ctor: Af y the fur	atic	1 Natural 5 Pending	ation	, Duy 70u	,, 11101			Yes 2□	No						
DIVISION	or Att	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 286. Place	of Injury - / ing, etc. (Sp	At home, farm, ecily)	street,	factory, office		2	8f. Location City or To	(Street a	t and Number or Rural Route Number, tate)			
2	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director,		29a, Certifier 1 Certifyin	a Physician: T. "	a bact -f	lemoust- d				4 = 1						
	24 ho Fun etely 1	Medical	(Check only 2 Medical one)	g Physicien: To the Exeminer: On the band man	e best of my easis of exam iner stated.	nination and/o	eath occ r investi	curred at the timi igation, in my op	ie, date an pinion, dea	d place, a th occurre	and due to the	e cause(s e, date an	s) and manner as : id place, and due !	stated. to the cause(s)		
	Vithin Fo the	Me	29b. Signature and title of certifier					29c. License	number			29d. Da	ate signed (Month,	Day, Year)		
	~		I ani ce i	- Ih	Mn			Dog	663	23		(6/20/0	4		
	(i)		30. Name and address of person		se of death	(Item 23a) (Ty	pe, Prin						1 - 6	7'		
	3			Hou,m		2031	Ne	St m	ain	37.	EIV	100	mox	1901		
	Sta Registr		31. Date filed (Month, Day, Year)		Redistrar's S	ignature	-	M -								
	ricgisti	CIT .	30112	. 2000	KJ8116.	D.	600									

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 7:55 P M Anna Margaret Croghan June 19, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 7514 Ridge Road Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 1 F 85 1/13/1921 MD Director 212-14-7856 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County Show ul Hygiene. other than "natural", or Items 23a or 28a-f shov vent, the Medical Exemilier must be notified at 1 ☐ Yes 2 1 No Frederick Director Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21702 7514 Ridge Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2XMarried Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Book Keeper Banking permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygiel Important: if Item 27 is marked other tt eny injury or other traumatic event, ILM page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Virginia Burke Guy Anders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7514 Ridge Road Frederick, MD 21702 Michael Croghan Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory | 6/21/2006 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service/Licensee Kan M01176 106 East Church Street Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ow dio my **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cur sequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) nding physicien ause as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. ete has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1☐ Yes 2 No after death.

Director: After this certific
d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ 1 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D51643 June 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV. Frederick MS 21702 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

				State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death		Reg. No.	20182
		Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year	3. Time of Death
"		/Medic	al -	Elaine H. Cole 45. City, Town, or Location of Dec.	June	20 2006 4c. County of Dea	
		Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Det Union Hospital E1kton	ап	Cecil	
	-			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	rs. 8. Date of Bir	db 0 Bi	thplace (State or Foreign
		Funeral Director		222-10-7239 1 M 2 N F 83 Yrs. Months Days Hours Mi	June 12	2, 1923 De	elaware
	P			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	laryla	shov a g	à				1 XYes 2 No
	the N	28a-f	Director	Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
1.	with	3a or		1 Price Drive 21921		United S	tates
12	death	me 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No erto Rican, etc.)	0- 14. Race - Am Black, Wh	
J	36 after	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Yes 2 🛣 No Specify:		Connibu	White
J	5-0036	ural",	q pe	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
La	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	an" n	plete	(Specify only highest grade completed) (Give kind of work done during most of will life. DO NOT use retired)	vorking		
2	2121	giene.	Completed by Funeral	12 Homemaker		In Her O	wn Home
3014	pu e	ital Hygiene. id other than "netural", or Iteme 23a or 28a-f show event, Tra Medical Exercitive must be rodified at	To Be (17. Fatilitis (17.5), America, Castry	, .	e, Maiden Sumame)	
(V	yla Sould	and Mental Hygiene. Is marked other than "netural", or Iteme 23a or 28a-f show aumatic event, the Medical Executar trust be redified at	၉	Sanford Halliday Pear. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	1 Hallmar Bural Boute Numb		Zip Codel
	Maryland	th and		Carolyn A. Cox/Daughter 63 Port Herman Drive			
	e .	Heal tem 2 other		20h Blace of Disposition (Name of	Date	20c. Location - City o	
	HOL	nt: If i		20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jun 20a. Method of Disposition Grace Lawn Memorial Park Jun 20a.	ne 23, 06	New Castle	, Delaware
	Baltimore,	Depertment of Health and Menta Importent: If item 27 is marked any Injury or other traumatic evonce.		21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Fun 103 W. Stockton S	nerals, E	P.A. Ekton. Marv	land 21921
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory	arrest,	Approximate Interval Between
	PI	hysician		Immediate Cause (Final disease or condition			Onset and Death
		/Medical xaminer		resulting in death) Due to (or as a consequence of):			
	ei:	*	-	Sequentially list conditions, if any leading to immediate b. MEASTATIC Briefs (Due to (or as a consequence of):	A		
*) pet	Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.			
	V.	sicien and burial-transit		resulting in death) Last Due to (or as a consequence of):			
	3760	nysicie he bul	cal	d			
~	ecords, P.O. Box 68760, Commonwealth	ettending phy	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		02d Date of d	a live and
	Воу	ettend for us	lan	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of d Month	Day Year
	O B	y the	yslc	1 Yes 2. No 9 Unknown			
	Q 2	igned by the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute	
	rds	been sig			_ 1□]Yes 2□No 3□I	Probably 4 Onknown
	ecc on a	as be	Completed		24a. Wa auto	s an 24b. Were a	autopsy findings available completion of cause of
	<u> </u>	cate h	Соп		1 ☐ Yes	formed? death?	
	of Vita	certificate has rector, page 2	Be	examiner? Hospital: Other	Death (Check only		
	to d	r this aral dir	: To	27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		sidence 6 🗌 Other (Sp how injury occurred	(ecity)
	ion	Attending of death. actor: After by the funer	atlor	1 Natural 5 Pending Injury Work? 2 Accident investigation M 1 Yes 2 No			
·	Division of Vital Records,	to the nospited or Australia Priyscratic. The law required within 24 hours after death. To the Funerel Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined 18e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or a own, State)	Rural Route Number,
		hours a		29a. Certifier —— Certifying Physician: To the best of my knowledge, death occurred at the little, date and ph	ace, and due to the	e cause(s) and manner	as stated.
	i i	ne no in 24 l he Fu pletely	edical	(Check only 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death o one) Additional Examiner: Of the basis of examination and/or investigation, in my opinion, death o one)	Courred at the time		
		To t Com	Σ	29b. Signature and title of certifie 29c. License number		29d. Date signed (Mo 2の よいいで	
) /Han D54073		10 300	
		3		30. Name and address of page in two completed cause of death (Item 23a) (Type, Print) Arlen D. Stone, M.D., 817 Churchmans Court, New Cast1	e DE 10	720	
	100	St	ate	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	.c, <i>DE</i> 19	140	
		Regist		31. Date filed (Month, Day, Year) JUN 2 7 2006 32. Referrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 **Physician** JUNE 2006 GREGORY SCOTT CONNOR 10:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 111 ARMSTRONG STREET FROSTBURG ALLEGANY Months Days Hours Min. SEPT. 3 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 **T**M 2 □ F 1966 CUMBERLAND, MD 39 Yrs. 218-04-2343 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'es Medical Exactical must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 111 ARMSTRONG STREET 21532 UNITED STATES Funeral Pages 1 and 2 should be filed within 72 hours after death vaned of Health and Mental Hygiene.
ansi: if item 27 is marked other than "ratural", or items 23a ansi: if item 72 is marked other than "ratural", or items 13a may or other traumatic event, it wite its in that man 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ⊕Yes 2 □ No If ¥es, Give Year or Dates: 1985-1989 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 录 No þ Specify: WHITE 3 Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry SHEET METAL WORKER Elementary/Secondary (0-12) College (1-4or 5+) HEATING & AIR CONDITION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KAY (WHITFIELD) DENSMORE CRAWFORD M. CONNOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 ARMSTRONG STREET FROSTBURG, MD 21532 KAY DENSMORE/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAEL CEMETERY JUNE 20,2006 FROSTBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET Sowers moo547 SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 Alan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EAR ANCREATI /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be d To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 Yes 1 Yes 2PNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending Nothin 24 hours after death.

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Sign State Registrar

DHMH 17 Rev. 1/2001

JUN 2 7 2006

ORIGINAL

			1 - For State Registrar	State o	f Maryla	nd / Depa	artmen <i>rtificat</i>			and M	lental Hy	giene	006	20184
	Dhucici	200	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Media		Patricia Joar	Crawfor	d		,				June	11	2006	10:00 A M
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10	Funeral		5. Social Security Number 578-36-4283	i.Sex 1 ☐ M 2 🔀 F	7. Age (In yrs	. last birthday) Yrs.	Months Months	Days	If Under Hours	Min.	8. Date of Bi	ay, Year)	9. Birth	nplace (State or Foreign untry)
-	Director		Usual Residence of Decedent		7.5						Sept.	5, 19	30 Pen	nsýlvania
	/land		10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
	Man	tor	Maryland Charle	es.		Wa 1	dorf							1 ☐ Yes X ☐ No
	h the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 ahow dical Examinar must be notified at	Funeral Director	2492 Quadrille C	Court					2060)2			US	
	r dea	iner	11. Marital Status	12. Was Dece Armed Fo d 1 \(\text{Yes}	edent Ever in I	U.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or Ne Rican, etc.)	0- 14	. Race - Amer Black, White	
98	or It	y Fu	1 Never Married 2 Marrie	If Yes, Giv	/8		1 🗆 Yes		Specify:					
5-0036	ural.	d by	3 Widowed 4 □ Divorced	Year or D	ates:	1 10 0							WI	nite
15	n 72 "nai	Completed	15. Decedent's (Specify only highest			Give	ident's Usu: <i>kind of wa</i> <i>DO NOT u</i> :	al Occupa rk done d se retired	ition Juring mos	t of workii	ng	16b. Kind	of Business/I	ndustry
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0	Hygin other ent,	BeC	17. Father's Name (First, Middle, La	ast)					18. Mothe	r's Name	(First, Middle	, Maiden S		
<u>a</u>	Mental Mental arkad o	To B	John Patrick McG	iowan					Mai	ry Es	ther B	oes		
Maryland	2 should and Men is marks aumatic	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ing Address	(Street a	nd Numbe	r or Rura	/ Route Numb	er, City or	own, State, Z	ip Code)
	and 2 satth a n 27 is		John T. Crawford	l - Son		11655	Bach	elor	s Hop	e Ct	., Swa	n Poi	nt, MD	20645
ore	of He		20a. Method of Disposition 1 XBurial 2 Cremation 3	L □ Removal from		Place of Disponentery, cre	osition (Nar matory or o	ne of ther place	a) !	D	ate	20c. Loca	tion - City or 1	Town, State
Ĕ	Pag ment ant: 1		4 Donation 5 Other (Spe		Re	esurrec	ction	Cem.		5-16-	-2006	Clin	ton, Mi)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperfinent of Heatih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 ahow any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be notified at another.		21. Signiture of Funeral Service Li	0000	M000	JJJ	2. Name ar			91000000				ton Road
	0 D = € 0		HOLLEY	Juhal	w		luntt			CONTRACTOR OF THE PARTY OF			aldorf	, MD 20604
*			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that only one cause on e	aused the dea ach line.	ath. Do not en	ter the mod	le of dying	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. J-9	ilun	e to	T	M	ive	2				months
4.0	Examiner			Due to	or as a conse	quence of):	iA A	117	F .					
	7.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	or as a conse	quence of):	IVIE	2111	w-	<u> </u>				Jeans
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	A-1	-her o	Scl.	eno	Si	5					1000
ó	exec an en rial-tr	Exa	resulting in death) Last	Due to	(or as a conse		0 (-	J (-					J. C. L. L.
8760,	The law requires that the death certificate be executed the sbeen signed by the attending physician end oage 2 should be detached for use as the burial-transit	edical		d										
9	ntifica ing pt	Med	IF FEMALE:											
Вох	eath certific attending p for use as (lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	tal death 3	⊒Ectopic pr	egnancy				23	d. Date of deliv	
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<u>α</u>	that the death led by the atter detached for u	P.	Part II. Other significant condition	s contributing to de	eath but not re	sulting in the t	anderlying c	alien ane	o in Part I		23a Did	tobacco use	contributo to	the cause of death?
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Ö	w requir been si should I	ete												
Re	reician: The law s certificate hes t lirector, page 2 s	Completed									24a. Was auto		prior to co death?	opsy findings available ompletion of cause of
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S	Physician: r this certificantal director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DC	Othe			Check only		☐Other (Spec	4.1
0	g Ph		27. Manner of Death	28a. Date	·	28b. Time o		8c. Injury			28d. Describe			ny)
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Division of	iracto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place	of Injury - At I	home, farm, st	reet, factory	, office		2	28f. Location (City or To	Street and I wn, State)	Number or Rui	ral Route Number,
	irs at													
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only 2 Medical Expense)	Physician: To the kaminer: On the b	asis of examin	newledge deat ation and/or in	h occurred restigation	at the tim , in my op	u datu an inion, dea	d place, a	and des to the ed at the time,	date and p	d mamer as ace, and due	stateu. to the cause(s)
	ithin 2 of the	Mec	29b. Signature and ittle of certifier	and man	ner stated.			. License					signed (Month	
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(30. Name and address of person w	ho completed caus	e of death (Ite	m 23a) (Tvne	Print)	9		,00			112	1 - 0
1	562,		Dr. Rakesh Aror					Sui	te 22	2, B	owie, I	MD 207	15	
1	Sta		31. Date filed (Month, Day, Year)	32. H	sistrar's Sign	nature	Anne V.	, o						
	Regist	rar	JUN I	5 2006		15 /6								

			1 - For State Registrar	State of Marylar		ent of Health and ate of Death	Mental Hygie	-2000	20185
	Physici /Medic		1. Decedent's Name (First, Middle, Last,		LES		2. Date of Death Month JUNE	Day Year 2 2006	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give CHR15 / DSD/ 5. Social Security Number 6. Second Security Number	CE CENTRA	last birthday) If Uno	ity, Town, or Location of Dea TOW SOM der 1 Year If Under 24 Hrs is Days Hours Min	8. Date of Birth	ar) Cou	place (State or Foreign
	Director word	_	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location		JAN. 8, 1	945 Buck	10d. Inside City Limits
AM	death with the Maryland me 23a or 28a-f ehow f.must.ce.notitled at	Funeral Director	10e. Street and Number 6905 LACKLA	w Circle	DU/SON 101.	Zip Code	10g.	Citizen of What Cou	1 ☑Yes 2 ☐ No
1231	s after	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puel	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: BL	
	- 6	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		☐ life. DO NO1	work done during most of we	orking	Kind of Business/Ir	
	BLC De file De file De oth	To Be	17. Father's Name (First, Middle, Last) CHARLES	ŒS		BET	me (First, Middle, Maid	TON	
-	Ma 2 s lith ar silth ar rtrau		19a. Informant's Name/Relationship (Ty DELORES RICHA) 20a. Method of Disposition	RUSON COLES	6905 L	Name of	ecté Tou		21239
6/12	Baltimore, permit. Pages 1 a Deperment of Hee Important: If Item eny injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen	emoval from State	Cometery, crematory of MITAS Survey	and Address of Facility		Noths burg	AL HONE
-	Attending Physician: The law requires that the death certificate be executed Table 1. So the state of the sta	dicai Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection)	quence of):	00 1	c or respiratory arrest,		Approximate Interval Between Onset and Death
0,	CO. BOX 68 In the death certific by the attending pl teched for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	al death 3 □Ectopic			23d. Date of delive	ery Day Year
	Cords, P	ed by PI	Part II. Other significant conditions cor	tributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ES	VITAI RECORDS, ilclan: The law requires t certificate has been signe rector, page 2 should be o	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available mpletion of cause of
	r VIta ysician: is certific director,	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	3 CB/O	0.4	ath Check only one		Haspie
	IIVISION Of Or Attending Physiter death. Viector: After this or by the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	10me 5 Residence 28d. Describe how in		WHO Spie
OF	2 4 4 5	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ify)		281. Location (Street City or Town, St	ate)	
4	Hospital	edicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my knower: On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occi	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	lly . n	O (29c. License number	29d.	Date signed (Month,	Day, Year) 2006
	5		30. Name and address of person who or	6-BMC		Chales St	Balto.	md Zi	201
	Sta Registi		31. Date filed (Month, Day, Year) 4 2	32. Projetrar's Sign	ature Look	re la la la la la la la la la la la la la			

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #27 per/phys CNM 06-14-2566 cate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** JUNE 11:15A M WILBUR LAWRENCE CLINE 10, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⅓**M 2□F Yrs Director 215-26-7708 Sept 8,1921 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. or 28a-f show Virginia Augusta Fishersville 1 ☐ Yes 2 ▼ No Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? r then "naturel", or iteme 23a or the Medical Examiner must be 22939 USA 32 St. Ives Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant if item 27 is marked other then "naturel", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pie Company 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Gladhill Lily Cline, Sr. Charles R. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32 St. Ives Dr. Fishersville, VA 22939 19a. Informant's Name/Relationship (Type, Print) Shirley S. Cline/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) 6/14/06 Middletown, MD Christ Reformed Cem 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 , tenton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4RRYTHMIA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) the signed by tid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEART FAILVICE 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 ☐ Yes Fo the Hospital or Attending Physicien: After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ို Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: / 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerei Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) D-57716 JUNE 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lalit Verma, M.D. Frederick, Maryland 21701 400 W Seventh Street 32. R State Registrar

		•	For State Registrar	State of M	aryland		artment of H tificate of L		and M		giene Reg. No.	2006	20	18
VI.	20 July 18		1. Decedent's Name (First, Middle, La.	st)						2. Date of De Month	ath Day	Year	3. Time of I	Death
	Physici /Medic		Richard Glenn Cle	ments, Sr.						June 9			7:35	P M
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location o	of Death		4c. C	County of Deat	h	
**		4	Montgomery Genera	1 Hospita:	1		Olney				I.	Montgom	ery	
	Funeral		Social Security Number 6. S	ex 7. Ag X M 2 F	ge (In yrs. la		If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birt	hplace (State or untry)	Foreign
with the same of t	Director		215-52-6451	ASIM ZUP	57	Yrs.				Mar. 2		49	DC	
	pu ≱	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d, Inside Cit	y Limits
	aryle ahov	٦											1 🗌 Yes	2 🔀 No
	Ba-f	ecto	MD Montgom	ery	Ga	ither	10f. Zip Code				10a Citiz	en of What Co	unta/2	
	with t	ā	10e. Street and Number										ditiy:	
	within 72 hours after death with the Maryland ane. than 'natural', or Itame 23a or 28a-f ahow ta Madical Exercines could be notified at	rai	8332 Hawkins Cr			12	20882		sin? (Cno	of Voc or No	USA	4. Race - Ame	rican Indian	
	er de	nue	11. Maritaf Status	12. Was Decedent Armed Forces 1 ☐ Yes 2 🛣	?	3.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican	n, Puerto I	Rican, etc.)		Black, Whit		
36	rs aft	y F	1 Never Married 2 Married 3 Widowed 4 YDivorced	If Yes, Give Year or Dates:	140		1☐Yes 2√∑No	Specify:			3	Specify: Wh	ite	
21215-0036	hou	ed	15. Decedent's E			16a. Dece	dent's Usual Occupa	ation			16b. Kin	d of Business		
7	in 72	oiet	(Specify only highest gra	ade completed)	-	(Give	kind of work done of DO NOT use retired	during most ()	t of workii	ng				
7	than than	mo	Efementary/Secondary (0-12)	Coflege (1-4or	5+)	Print	er				Pri	nting		
0	Hyg other	0	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle	, Maiden S	Витате)		
an	id be ental ked c ev	0 8	Warren Leroy Cle	ments				Bes	ssie	Payne				
Maryland	Shound M	-	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street a	and Numbe	er or Rura	l Route Numb	er, City or	Town, State, 2	Zip Code)	
Ž	nd 2 lith a 27 Is		Richard G. Clements,	Jr. / Son		8332	Hawkins Cre	amerv :	Road.	Gaither	sbura,	MD 2088	2	
5	F Hear		20a. Method of Disposition		CA	ace of Dispo	sition (Name of matory or other plac	-	D	ate		ation - City or		
5	age it		1 ☐ Burial 2000 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		•		n Crematory	J	une 1	2006	Alexa	ndria, V	A	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturat", or Itame 23a or 28a-f show am portant: if Itam 27 is marked other than "naturat", or Itame 23a or 28a-f show amount in July go other traumatic avant, the Medical Examination content and Italia at once.		21. Signature of Funeral Service Lice			2:	2. Name and Addres	ss of Facilit	ty					
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7	*		23a. Part Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death	. Do not en	er the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,	nig, riv	Approximate Interval Bety	
	D1		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	0 0		0		1 n. 1	100	116	0 4 4 5	A b-
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Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy	,			2:	3d. Date of de		
	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (specify)					Month	Day Y	'ear
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ğ	quire nn sig uld b		ALCOHOLI.	Sm					_	1 🗆	Yes 2	No 3 4	obably 4 🗆 U	Inknown
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	n 24 n 24 ha Fu	Medical	one)	and manner s	stated.	ion and/or ir	vestigation, in my o	pinion, dea	un occum	ed at the time,	, date and	piace, and due	to the cause(s))
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	7		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)						1	
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	/Medic Examir		4a. Facility Name (If not institution, give streeth LAVREL REGISMA (M)			1 .	, Town, or	Location of		70140	4c.	County of I	Death	30266	ř
	Funeral Director		5. Social Security Number 6. Sex 213-40-9129 1 X M	7. Age	(In yrs. last birtho	Months	or 1 Year Days	If Under 2 Hours	4 Hrs. 8	Date of Bir (Month, Da (uly 1)	igus 2, 1	t 30, 9. 910 Ro	Birthpla Count DMan	ace (State rry) 11a	or Foreign
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Baltimore, Maryland 21215-0036	and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. m 27 is marked other than "nature!, or iteme 23a or 28e-1 show per treumatic event, the Marical Exeminar man be notified at	ted by Funeral	1 Never Married 2 Married 3 Never Married 4 Divorced	Was Decedent Evanued Forces? 1X Yes 2 Note Note 1	ver in U.S.	13. Was Dece If Yes, spi 1 Yes	edent of Hi ecify Cuba	Specify:	in? (Specr Puerto Ri	ty Yes or No can, etc.)	-	14. Race - A Black, V Specify: V	America Vhite, e vhit	an Indian, atc.	
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	\$		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final	ause on each line).	254 Ca	arrol de of dying	1 St.	, NW , ardiac or r	Washi	ingto			0012 Approxima Interval Be Onset and	ween
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.O. Box 68760,	The law requires that the death certificate be- sie has been signed by the attending physicia page 2 should be detached for use as the bur	by Physician/Medical I	in the past 12 months?	If yes, outcome of 1∐Live birth 2 4∐Pregnant at ti 9∭Unknown	Fetal death	3 □Ectopic p					2	23d. Date of Month		,	Year
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		Me	29b. Signature and title of certifier				c. License					signed (M			
1	V		30. Name and address of person who complete the complete	eted cause of dea	ath (Item 23a) (Ty 10724	pe, Print)		`	PKW						4
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Development of Carriol Hospital Center Formation Form			4	- For Amend #23a-d& Registatend #20b, cperif	State of Ma 23Pii Per 16/12/06,BW	PHY G85	epartmer 7/03/ Certifical	t of Healt For Dea	h and I	Mental Hygi	ene2 () () g. No.	6	20189
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 12. 2006		D		30. Name and address of person who CIMENGA T	completed cause of	death (Item 23a) (Type, Print)	HINGTO	N HE	IGHTS	WEST	m(K	STER 21157
				31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Apen	9					

Amend #1 per Phy 6/9/06 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ÁA Co. Health lo State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dev Year Month Vera Virginia Christenson Physician 06 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (ff not institution, give street end number) Examiner Anne Health a Re Hrundel ritage -bou If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yea If Under 1 Year Months Devs Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Deys **Funeral** 1□M 20 F 82 Yrs. 215.84-8854 24 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours efter death with the Merylenc 10a. State 10b. County 7 is merked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Edgewater MD Anne Arundel 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21037 200 Holly Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ◯XNo White Specify Specify: Be Completed by 3€XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flam 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William E. Tucker Sara E. Hardestv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Hull (Daughter) 307 Holly Road, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2006 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 905 Galesville Road, Galesville, MD 20765 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 101 Examiner Physician/Medicai Examiner buriel-trensit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury eted events Due to (or es a consequence of) es the resulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case Be Certification: To 1 Yes 27. Manner of 1 Natura 2 Accide 3 Suicid 4 Homi edical 29a. Certifier

Hospital or Attending Physician: The law requires thet the death certificate be executed Box 68760, Division of Vital Records, P.O. within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu ŧ,

Maryland 21215-0020

Baltimore,

				1 Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner?	Hospital:	ER/Outpatient 3□ (OOA Other: 4 Ownsing	Home 5 ☐ Residence 6 ☐ Othe	or (Specify)
27. Manner of Dea 1 1 Patural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	be
3 ☐ Suicide 6 ☐ Could not to determined		nome, farm, street, factority)	ory, office	28f. Location (Street and Number City or Town, Stete)	er or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Place 2 Medical Example 1	nysician: To the best of my knominer: On the besis of examination and manner stated.	owledge, death occurre ation end/or investigation	d at the time, date end placen, in my opinion, death occ	ce, and due to the cause(s) and mar curred at the time, date and place, a	nner as stated. Indidue to the cause(s)
29b. Signature end title of cartifier		2	9c. License number	29d. Date signed	(Month, Day, Yeer)
· W	well	00	200578	97 6/1	106
30. Neme end eddress of person who	completed cause of deeth (Itel	m 23e) (Type, Print)	Let Drive	e Ste 100 E	Micht City 2106
31. Dete filed (Month, Pay Year)	2006 32. Signistrer's Sign	atur	0.0		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2 0 0 0

	1	For State Registrar	State of Ma		ertificate of L			Reg. No.	
Physicia		. Decedent's Name (First, Middle, Las.					2. Date of Dea Month	Day Year	3. Time of Death
Physiciai Medica	1	Ronald G. Clant			th City Town or	Language of Dooth	Jun.	6, 2006 4c. County of Dea	1.05p
Examine	r 4	a. Fecility Name (If not institution, give Anne Arundel Me		tor	4b. City, Town, or	Annapoli	S	Anne Ar	
		. Social Security Number 6. Se		e (In yrs. last birthda	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bird (Month, Da	b O Bir	thplace (Stete or Foreign
Funeral Director			X M 2□F	76 Yrs.	Months Days	Hours Min.	Dec. 2		MA
D. J.	⊢	Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
shov		MD Anne Ar	rundel	100, 01,9, 101111		nold			1 ☐ Yes 2 ☑ No
the N	ect	De. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
3a or	Funeral Director	1039 Placid Cou	ırt		2	1012		US	Α
death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Ame Bleck, Whi	
LIS a	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		1☐Yes 2☐No				White
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de com <i>pleted)</i>	(G	cedent's Usual Occupa	luring most of work	ing	16b. Kind of Business	/Industry
nithin New Med	du	Elementary/Secondary (0-12)	College (1-4or 5		e. DO NOT use retired)		Westingh	ouse
tygier her th	ဂြ ပ	17. Father's Name (First, Middle, Last)	5 +		Engineer	18. Mother's Nam	e (First, Middle	. Maiden Sumame)	
ould be fit Mental H Marked oth	മ്	Henry Clanton				Phyllis	Grahan	n	
2 should be and Mental I smarked o	ို	19a. Informant's Name/Relationship (1	Type, Print)	19b. M	ailing Address (Street a	and Number or Rur	al Route Numb	er, City or Town, State,	Zip Code)
and 2 shealth and m 27 ls r		Rosemary D. Cla	anton/Wife		039 Placid		Arnold,		
permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			sposition (Name of crematory or other plac Crematory		. 8, 006	Baltimore	
permit. Pages Department of Important: If It any injury or o	Ì	21. Signature of Furneral Service Licer	A/Cen		Barranco 495 Gov.	& Sons, E Ritchie H	P.A. Sev Hwy, Sev	verna Park verna Park,	Funeral Home MD 21146
A,	1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	310 02000 317 0237 11		t attack				Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of):					
Examiner		Sequentially list conditions,	b. Due to for as	a consequence of):					
ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence on.					
ifficate be executed g physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
ficate be ex physicien s the buria	edical		d						
tificat ng phy as th	Medi	IF FEMALE.							
th cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy			23d. Date of de Month	elivery Day Year
at the death certainty the death certainty the attendir etached for use	/sici	1 Yes 2 No	4∏Pregnant a 9∏Unknown	t time of death	5 Other (specify)				
ires that the death certifules that the death certifules to the attending of the detached for use a	by Physician/M	Part II. Other significant conditions	contributing to death I	out not resulting in th	ne underlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
signe d be		Coronary Av					1 🗆	Yes 2₩No 3□F	Probably 4 Unknown
w require	Completed						24a. Was		utopsy findings available
he lav e has age 2	duc						auto perf	ormed? death?	completion of cause of
vicien: Th	0	25. Was case referred to medical				26. Place of Dea			
Physici Physici this cer al direct	To B	examiner? 1 ☐ Yes 2 🕵 No	Hospital:	ent 2 ER/Outp	atient 3 DOA Oth	er: 4 🗆 Nursing H	ome 5□Res	idence 6 Other (Sp	ecify)
on o ding Ph h. After th funeral		27. Manner of Death 11 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, Da		ury Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occurred	
DIVISION OF VITAL RECORDS, if or Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification:	3 Suicide 6 Could not be determined	200. Flace Ul II	njury - At home, farm tc. (Specify)	n, street, factory, office			(Street and Number or Fown, State)	Rural Route Number,
DIVISION OF VITAL RECOIDS, F.O. BOX Of the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical Co	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination and/	death occurred at the fir or investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	a cause(s) and manner a , date and place, and du	as stated. ue to the cause(s)
o the o the omple	Me	29b. Signature and title of certifier	20-11		29c. Licens			29d. Date signed (Mor	nth, Dey, Year)
F 5 F 0		> Dole	Bech, 6	W	D:	46052		010/01	3
		30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print) V Panhwan	y anno	polos,	MD	
Sta Registi		31. Date filed (Month, Day, Year)	2006 32. egis	trar's Signature	hools				

			1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cei</i>	artment o	of He	ealth a Death	and M		jienę) eg. No.	006	20	192
	Olever lad		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month		Year	-	of Death
	Physici /Medio		WALTER F	COX	JR.						TUNE	11	2006	01 2	25 AM
	Examir	er	1100071110	NTY GENE				LUI	MBiA	9			WARN		
	Funeral Director		5. Social Security Number 411 64 1536 Usual Residence of Decedent	7. Age		st birthday) Yrs.	If Under 1 Y Months Da	ear ays	If Under Hours	Min.	8. Date of Birth (Month, Day July 27	Year) , 194	Cou	place (State intry) nesse	e or Foreign
	show		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	Many a-f sh	to	MD Howard		E11	icott	City							1 □ Ye	s 2X No
	th the	irec	10e. Street and Number				10f. Zip Co	de			1	0g. Citizer	of What Cou	intry?	
	23a (23a)	al	9502 Westwood Drive	2			210	42				Uni	ted St	ates	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Mcdital Examinar must be notified at	by Funeral Director	11. Marital Status 12 1 □ Never Married 2 【X Married	Was Decedent B Armed Forces? 1 XYes 2 N If Yes, Give	io		Was Decedent f Yes, specify I □ Yes 2 🖫	Cuban	panic Ori , Mexican Specify:	gin? (Spec n, Puerto F	cify Yes or No- lican, etc.)		Race - Amer Black, White		
21215-0036	ural',	d b	3 Widowed 4 Divorced	Year or Dates:	1960-	64						Sp	ecify: Wh	ite	
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12	withi	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)		Compute	,				NSA			
d	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				Jaipau		18. Mothe	r's Name	(First, Middle, I				
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M.	To B	Walter F. Cox, Sr.						Merl	e Dio	ckerson				
ary	2 short and N ls ma		19a. Informant's Name/Relationship (Type	Print)		19b. Mailir	g Address (St	reet ar	nd Numbe	or or Rural	Route Number	, City or To	own, State, Zi	p Code)	
Σ	and 2 palth n 27 ler tra		Judith E. Cox/Wife						Driv	e El	licott (City,	MD 21	042	
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ren	noval from State	20b. Pla	ice of Dispo metery, crem	sition (Name of natory or other	of place,)	Da	ate	20c. Locat	ion - City or T	own, State	
Ë	Pag tment tant:		* 4 □ Donation 5 □ Other (Specify)								-2006 1				
Baltimore,	permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other tra ance.		21. Someture of Funeral Service Upensee	Afte 1	40104					_	y H. Wi ike Ell				
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions/that caused cause on each lin	the death. e.	Do not ent	er the mode of	dying,	such as	cardiac or	respiratory arre	est,		Approxim Interval B	etween
	Physician	6 1	Immediate Cause (Final disease or condition resulting in death)	VE	NTR	icul	AR FIR	SRI	LLAT	PION				Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a	,	,	0	200	1071	0.43					
	TIE	- G	Sequentially list conditions, b.	Due to (or as a			AL INF	HI	40 (12	7/0	_		_		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	ORUI	VARY	ARTI	427	Dry	CASE					
o,	exec an an		resulting in death) Last	Due to (or as a											
8760,	icate be executed physician and s the burial-transit	dical	d.												
9	n certifica anding ph use as th	Med	IF FEMALE:												
Box	atte	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 □ Fetal d	leath 3 [Ectopic pregna Other (specif)					23d	Date of delive Month	ery Day	Year
P.0	at the ded by the etached	Phys	9 Unknown					-							
Records,	w requires that been signed I should be det	by	Part II. Other significant conditions contri DYSLIPIOCOV		it not result	ing in the ur	iderlying cause	given	in Part I.			s 2 \square N	contribute to to	he cause of pably 4	
ဝ၁	e law requ has been je 2 shoul	Completed									24a. Was ar		4b. Were auto	psy finding	s available
E .		Con									perform	ned?	death?		Cause of
Vital	i cian : Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only on	9)			
of	를 끌 등	5	1 162 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	pital: 1 🔲 Inpatier		R/Outpatien		Other	4 LI Nui		e 5 🗆 Reside			y)	
Lo	ling I. After fune	Certification;	- Contains	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury		Injury a Work?	at es 2 🗆 N		3d. Describe ho	w injury o	curred		
Division	or Attending after death. Director: After in by the fune.	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	rv · At hom	e. farm. stre			53 &	pine.	3f. Location (Sti	reet and N	umber or Bura	i Route Nu	mher
Ö	i Si te	erti	4 Homicide determined	building, etc	. (Specify)		, rabioly, 61.	.00			City or Town	, State)	anibor or ribre	11100101140	mber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	an: To the best of On the basis of and manner stat	examinatio	edge, death in and/or inv	occurred at th	e time	, date and nion, deat	d place, ar h occurred	nd due to the ca	use(s) and ite and pla	I manner as s ce, and due to	tated.	(s)
	o the	Me	29b. Signature and title of certifier	1			29c. Lic	ense r	number		25	d. Date si	gned (Month,	Day, Year)	
	->-0		Showard	one	Farm	LA-Pa	DOM, MD,		502	35		ju	NE 1274	, 2006	Ś.,
92	Um		30. Name and address of person who comp	eleted cause of de	ath (Item 2			/ D	550	v Ro	AP JUITO				
:	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3	32. Registra	s Signatui	re							1 - 1 - 1		

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 Boy Cameron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner GAH, MAE
If Under 1 Year I If Under 24 Hrs. HOPKINS Johns None Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□F Yrs. 24 June 8. Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f ehow the Medical Examiner must be notified at 1 TYes 2 □ No Directo Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1305 Huntley Circle 21727 United States deeth Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. δ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) N/A None None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 le marked otf jury or other treumatic even Anthony Scott Cameron Michele Elizabeth Estanich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cathy J. Estanich / Grandmother 12508 Wolf Den Court Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State June 14, 2006 Depertment of Importent: If eny injury or once. 5 Other (Specify) Frederick, Maryland Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign rure of Funeral Service Licenses 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 weeks Extreme prematurity /Medical Due to (or as a consequence of): Examiner chorioamnioiti 10 weeks Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to or as a confequence of): run ture and physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2⊿No 1 Yes After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 1_Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: Division 1 Natural 5 Pendina To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 June 8 2006 MD and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Me

Colleen 31. Date filed (Month, Day)

(ormick

600

gistrar's Signature North Wolfe Street

Baltimore Maryland

21287

Box 68760.

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Records, P.

of Vital

			State of Maryland		rtment of H			2006	20194
			Registrar 1. Decedent's Name (First, Middle, Last)	- 001	incate or i		2. Date of Deat	9.110/-	3. Time of Death
	Physici		WILLIAM M.		CLARK,		Month JUNE	Day Yea 11 2006	
	/Medic Examin	195	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of De	
1	98#		Forest Hill Health & Rehabilita	tion	Forest			Harfor	:d
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last 228–24–4908 1 \ \frac{1}{2}\ \text{M} \ 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Months Days	Hours Min.	B. Date of Birth (Month, Day,	Year)	irthplace (State or Foreign Country)
	Director		228-24-4908 Psual Residence of Decedent	115.			Tan 23,	1928	Virginia
	/land			Town or Loc	cation				10d. Inside City Limits
	a-fer	ctor	Maryland Harford		Fore	est Hill			1 X Yes 2 ☐ No
	or 28	Olre	10e. Street and Number		10f. Zip Code	04050	1	0g. Citizen of What	Country?
	ath w	ral	1907 Lincoln Road	12.1		21050	itu Vaa as Na	USA	merican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Narried 12. Was Decedent Ever in U.S. Armed Forces? 1 Narried Forces?	If	was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ican, etc.)	Black, W.	
21215-0036	72 hou natura	ted	15. Decedent's Education	16a. Deced	lent's Usual Occup	pation during most of working		16b. Kind of Busines	ss/Industry
215	within 7 ene. than "n	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. E	DO NOT use retired	d)			
	filed with Hygiene. other than	Completed	5+		Adminis		(Fire A 44 days - 4		lgh School
Maryland	ould be fill Mental H mrked oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Ž	s 1 and 2 should be I Health and Mental Item 27 is marked o other treumatic eve	ဥ	Charlie Clanton Clark 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	Ella Will			, Zip Code)
Ma	uth an 27 is r treu		Meta G. Clark / wife			Road, For			
ē,	s 1 ar if Hea if Hea othe		cem	ce of Dispos	sition (Name of natory or other place	Da		20c. Location - City	
E	Page nent o int: If iry or		1 NJ Burial 2 ICremation 3 Hemoval from State		United		6/06	Havre de	Grace, MD
Baltimore,	permit. Pages Department of h important: If Ite any injury or of		21. Signature of Funeral Service Licensee	22	Name and Addre	ess of Facility Nott Funera Vis Street,	l Home,	P.A.	MD 21078
	,		23a, Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	ng, such as cardiac or	respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ne	ortite	ameer	-		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequent	nce of):					
1		-e	Sequentially list conditions, Jany Janobo to mundate Due to for as a consequent	nce of):					
	uted ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ó	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequent	nce of):					
8760	cate be exphysician	dicai	d						
9	e as t		IF FEMALE:						-
Вох	requires that the death certificate leen signed by the attending phys hould be detached for use as the	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months?	leath 3 🗆	Ectopic pregnancy Other (specify)	y		23d. Date of o Month	delivery Day Year
P.0.	t the de	nyslo	1 Yes 2 No 9 Unknown 9 Unknown	0	3 Other (apoonly)				
	res that igned b	y P	Part II. Other significant conditions contributing to death but not resulting	ing in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w require been sig should b	edb	enufledetally				1 🗆 Ye	es 2 No 3	Probably 4 Unknown
Z4a. 11								sv prior t	autopsy findings available o completion of cause of
E		Con					perform 1 Tes	med? death 2 No 1 □ Y	es 2 No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?		. all post Oth	26. Place of Death			
of	y se	-T	1 Tes 20040 1 Inpatient 2 EH	PVOutpatien 18b. Time of	I 3L DOA	4 Nursing Hom		ence 6 Other (Si	Decify)
O	ding th. After	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Wor	rk? Yes 2 □No		,,	
Division of	Atten r dea ector by the	Ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office	21	8f. Location (SI City or Town	treet and Number or	Rural Route Number,
Ö	s after or all Olr	Certification:	Building, atc. (Specify)				Only of Your	n, oluto)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle control on the basis of examination and manner stated.	edge, death in and/or inv	n occurred at the tir vestigation, in my o	me, date and place, ar opinion, death occurre	nd due to the ca d at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier		29c, Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
			Dave SD			2275	J	True 12,	2061
	0 1		30. Name and address of person who completed cause of death (Item 2:						
150	9+/VA	ate	Dr. David Dunn, 615 West MacPha: 31. Date filed (Month, Day, Year) 32. Registrar's Signatur	il Ro	ad, Ste.	106, Be1	Air, MD	21024	
1	Regist		31. Date filed (Month, Day, Year) JUN 1 3 2006 32. Regetrar's Signatur	13 1	Goods				

		4	For State Registrar		State of	of Maryla	and / Depa	artmen			and M	lental Hy	(2008	5 20	195
			1. Decedent's Name (First, Mic	idle Last)			00.	imean	5 01 2	Jean		2. Date of De	Reg. No.		3. Time o	of Death
	Physicia				_	D-111 -						Month	Day 16	2006		
	/Medic	_	Esther 4a. Fecility Name (If not institu	Winor		DeWit	L	4h City	Town, or	Location of	of Death	June		County of De		
	Examin	er	Dennett Road				me		klan				Ga	rrett		
	: Europel		5. Social Security Number	6. Sex			rs. last birthday)	If Under	1 Year	if Under		8. Date of Bi (Month, D			inthplace (State Country)	or Foreign
	Funeral Director		215-26-9332	10	M 2√2 F	75	Yrs.	Months	Days	Hours	Min.	Aug. 2	7 193	0 Ma	aryland	
			Usual Residence of Decedent												10d. Inside (Dib. Limito
	irylar show	_	10a. State 10b. Coul	ty			City, Town or Lo	ocation								s 2 🗆 No
	Ba-f:	5	MD Garr	ett		0	akland		-				40- 02-	en of What C		
	or 2	Director	10e. Street and Number					10f. Zip							•	
	death with the Maryland ms 23a or 28a-f show r must be notified at	<u>e</u>	1100 Mary Dri		10 W . D .	edent Ever in	11.6		550	ianania Ori	nin2 /Sn	neifu Von or N		ed Sta	erican Indian,	
	er de Itam	Funeral	11, Marital Status 1 ☐ Never Married 2 ☐ M		Armed F		10.5.	If Yes, spec	ofy Cuba	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	,	Black, Wh		
36	rs aft	by F	3 → Widowed 4 □ Divord	i i	If Yes, Gi	ive		1 🗆 Yes	2 XN0	Specify:				Specify:	White	
Ş	within 72 hours after ene. then "neturel", or Ita he Medical Eraticity	Pe	15. Deced	lent's Educ	cation		16a. Dece	dent's Usua	al Occupa	ation			16b. Kin	d of Busines		
5	n 7	plet	(Specify only hig Elementary/Secondary (0-1)		College (life.	kind of wo DO NOT u	rk done d se retired	during mos ()	t of work	ng				
2	d wit	E	12				Но	memak	er				Own	Home		
2	e filed	Be Completed	17. Father's Name (First, Midd	le, Last)						18. Mothe	er's Name	(First, Middle	, Maiden S	Sumame)		
<u>a</u>	Vents Ments rice	2	John Rowa	n						An	4	Paugh				
Maryiand 21215-0036	2 should and Men Is marke eumatic		19a. Informant's Name/Relation				1	•				al Route Numi			, Zip Code)	- 1
≥ .	and and n 27 n 27 ner tr		Sharon Rohrba	ugh,	Daugh					Road,		cland,			Town Chate	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If team 27 is marked other then "netural", or teams 23a or 28a-f show eny fully or other treumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Crematic	an 3 □P	emoval from	State	b. Place of Dispo cemetery, cre	matory or c	ther place				200. Loc	ation - City o	or Town, State	3
<u>=</u>	Peges ment of tant: If It lury or o		° 4 □ Donation 5 □ Other			I	leasant							land,		
쿒	Depart Import import eny in		21. Signature of Funeral Serv	ce License	98		2	2. Name ar							al Home	
ш_	₹0.5 € a	\Box	Katherin	0	Swee	her	D							ind, M	D 21550 Approxima	ate
			23a. Part1. Enter the disease shock, or heart failure.	ist only or	ne cause on	each line.			1 .			1	allost,		Interval Be Onset and	etween
	Priysician		Immediate Cause (Final disease or condition resulting in death)		ı		nsm:	114	211	DVCV	how	26 11	ne		N 50	(VS
	/Medical Examiner		resolvang in dodwin	•	Due to	(or as a con	sequence of):						_			
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89	eath certificat ettending phy I for use as th		n 1 1	-	-					-						2/1
Вох	andin use	ĬŽ.	IF FEMALE: 23b. Was decedent pregnant	2		utcome of pre		⊒Ectopic p	regnancy	,			2	3d. Date of d	_	Year
	deat	Sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No			nant at time		Other (sp						Month	Day	r B al
о. О	The law requires that the death certifica sie hes been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	9 Unknown		_							one Did	tabaasa	no contributo	to the cause of	doath?
	the digner	þ	Part II. Other significant con-	litions cor	ntributing to	death but not	resulting in the	underlying o	ause give	en in Paπ i					Probably 4	
or d	v requir been si should	ted										1000			2010-001-0	
Ö	e law hes b	P P										24a. Wa auto		24b. Were prior to death	autopsy finding o completion of	s available cause of
Vital Records,		Completed										1 □ Yes		1 🗆 Ye		
/ita	Physician: Th this certificate ral director, pac	Be	25. Was case referred to med examiner?		lospital:				. Othi	05	-	h (Check only				
ð	Physi this c	၉	1 Yes 2 No		1 [2 ER/Outpatie		JA	4 Line	Irsing Ho	me 5 Res 28d. Describe			pecify)	
ă	ng fer iner	o	27. Manner of Death 1 □ Natural 5 □ Pe		(Mo	of Injury nth, Day Yea	r) Injury	M	28c. Injun Worl 1 □	k?" Yes 2.□	No	Edd. Doscribe	now injury	00001100		
is:	Attending r death. ector: Atie by the fune	Cat	3 Suicide 6 □Co	estigation uld not be	28a. Plac	e of Injury - A	At home, farm, s					28f. Location	(Street and	Number or i	Rural Route Nu	mber,
Division	or A efter Direction by	Certification;	4 Homicide de	ermined	buile	ding, etc. (Sp	ecify)	.,	,,			City or To	iwn, State)			
	spital ours neral filled						knowledge, dea									
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medi	cal Exami		basis of exam nner stated.	nination and/or i	nvestigation	i, in my o	pinion, dea	th occur	red at the time	, date and	place, and d	ue to the cause	(s)
	To th within To th	ž	29b. Signature and title of cer	tifier				29	c. Licens	e number				F	nth, Day, Year)	
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			30. Name and address of per	on who k	ompleted car				CL	11	111	nd	1111	21	550	
	. ::		Thomas to	-	MSA		linto	wth	-T	00	wi,	nd	WV D	21	- 50	
		ate	31. Date filed (Month, Day, Y		2006	Registrar's S	ignature	Annal	8 9							
	Regist	reli	JUN	T A (_000	人员制度	B BAT B	はないので	247							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 1:55 P.M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) Months 1 ☐ M 2XF Yrs 293 18 9024 1923 Ohio Director 82 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic svent, the Medical Examiner must be nutified at 1 TYes 2 XNo by Funeral Director Ellicott City MD Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21043 United States or items 23e 5010 Avoca Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. iit. Pages 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene. If tem 27 is marked other then "neturel; or ite 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CSX Computer Programmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha Swoggers Raymond Lutz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1195 Ridge Rd Mount Airy, MD 21771 John W. Davis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Metro Crematory 6-13-2006 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Importe
any inju 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Lic M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 25XNo be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗆 No this certificate 1 ☐ Yes 1 Tyes 2 × No I or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 5 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pendina 1 Tyes 2 No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier UNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 4 2006

- KORY
32. Resistrar's Signature

			For State Registrar	State	of Marylan		artment of H tificate of I			iene g. No. 2006	20197
			1. Decedent's Name (First, Middle	le, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Stan	ley E.	Duva11				June 9		10:15A M
1	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			Shady Grove Ad				Rockv:			Montgom	
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director		220-50-6249 Usual Residence of Decedent		49	113.			Aug. 5,	1956 Mar	yland
	and wo		10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	f ehc	ğ	Maryland Mont	gomery		Damas	cus				1 □ Yes 2 XNo
	28a	Director	10e. Street and Number	<u> </u>			10f. Zip Code		10	g. Citizen of What Co	untry?
	3a o		27605 Ridge R	oad			208	872		USA	
	death	Funerai	11. Marital Status		cedent Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame Black, White	
9	after or its	Ē	1 Never Married 2 ☐ Mar		2 □ No		1 ☐ Yes 2 ☐ No	Specify:	rtican, etc.,	C-asit	
ဗ္ဗ	hours after death with the Maryland tural', or Iteme 23a or 28e-f ehow al Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:					WI	nite
ν. V	72	Completed	15. Deceder (Specify only highe	nt's Education est grade completed	i)	(Give	tent's Usual Occup kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Business/	Industry
Maryland 21215-0036	within ene. then	du	Elementary/Secondary (0-12)	College	(1-4or 5+)		tenance			U.S. Gover	nm on t
7	illed v i Hygie other i		12 17. Father's Name (First, Middle,	Last)		Hall	iteliance .		ne (First, Middle, M		Innent
an	a is b	Be		Duvall,	Sr.			Miria		Baublitz	
7	should be and Mental s marked o umatic eve	은	19a. Informant's Name/Relations		21.	19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)
	end 2 sho saith and n 27 is m		Gerald L. Duv		- Brotho						8
ē,	- I = =		20a. Method of Disposition	GLLS JIS.	20b. P	lace of Dispo	sition (Name of natory or other place			20c. Location - City or	
9	0 0 = =	3	1 XBurial 2 ☐ Cremation 4 ☐ Dimatico 5 ☐ Other (S		n State		Cemetery		3/06	Damascus, 1	Maryland
Baltimore,	그 돈 본 분	4 1	21. Signature of Fundinal Service) 22	. Name and Addres	ss of Facility	D 4	. 1 11	
ä	Deperminpo		Forest 2	. Hil	lum					Funeral How Maryland	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that	t caused the deat						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		-54	2129	SYND	ROME			Onset and Death
4	/Medical		resulting in dealh)	a. Due t	o (or as a conseq	uence of):	Door	MONI	٨		<u>-</u>
ш	Examiner		Sequentially list conditions,	b	LEFT.	110ED)	PNEL	MONI	A		
	D #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conseq	uence of):					
	ecute and trans	Examine	that initiated events resulting in death) Last	C	o (or as a conseq	uosoo of):					
8760,	cate be executed oblysicien and the burial-transit	a E			o (or 23 2 corisoq	derice (1).				Ĭ	
687	icate phys s the	edical		d							
Box (death certifica attending ph d for use as the	×	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pregna	incy				23d. Date of del	iverv
m	atter for u	ciar	in the past 12 months?		birth 2 ☐ Feta gnant at time of d		Ectopic pregnancy Other (specify)	'		Month	Day Year
о. О.	at the de by the	Physician/M	9 Unknown	9□ Unl	rnown						
ر ا	res tha igned I be det	by P	Part II. Other significant condit	ions contributing to			nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b		MO14131 D 01	767114,	CONGE		HEARLI	PAIWILL	, 1 ☐ Ye	s 2□No 3□Pr	obably 4 ØUnknown
900	e law re has bee ge 2 sho	pet	JENNE JYIN	ILL DY.	11-UNC	NUN	MEDA	BOLIC	24a. Was ar	24b. Were au	stopsy findings available completion of cause of
ž	The I	Completed	SYNDROMI	5.					perform	ned? death?	2 No
ita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	al				26. Place of Dea	th (Check only one	a)	
¥ <	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier		4 🗆 Nursing 🗖	ome 5 Reside	nce 6 Other (Spec	cify)
פֿח	ding Ph h. After th funeral	e E	27. Manner of Death 1-2 Natural 5 ☐ Pendi	/14.	e of Injury onth, Day Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurred	
sio	tendi leath. tor: A	cati	2 Accident invest	igation				Yes 2 □No	000 1 1 100		
Division of Vital Records,	or At	Certification:		nined 286. Pta	ce of Injury - At he tding, etc. (Specif	ome, farm, sti	eet, factory, office		City or Town	reet and Number or Ru , State)	irai Houte Number,
u	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifyi	na Physician: To t	he hest of my kno	wiedne dest	occurred at the time	ne date and place	and due to the co	use(s) and manner as	stated
	24 hc Fun etely	Medical	(Check only 2 Medica	I Examiner: On the	basis of examina anner stated.	ition and/or in	vestigation, in my o	pinion, death occu	rred at the time, da	ite and place, and due	to the cause(s)
	of the office of	Me	29b. Signature and title of certific		1		29c. Licens	e number		d. Date signed (Monti	
	~ ≤ ⊢ ō		* K. flu	oundown	DON		05	3367		TUNE 912	, 2006.
	17-	1	30. Name and address of person		use of death (Iter	n 23a) (Type,	Print) 341	1, Olami		var, Juine	
	10		OLNEY, M	D. 20837				,			- 10 - 2 0.
-17		ate	31. Date filed (Month, Day, Year	4 2006	egistrar's Signa	atura /	mel				
	Regist	rar	I NUL I	4 7000	your .	7	-				

			1 - For State Registrar	State of Maryland		artmen rtificate			and Me	-	giene Reg. No	21111	5	20	98
	Physici	an	Decedent's Name (First, Middle, Last)						2	2. Date of De Month	Da	-		3. Time of I	
	/Medio		4a. Facility Name (If not institution, give	David Anthony street and number)	y Dods		Town, or	Location of		une	10	2006 :. County of D		6:30p) M
	LXaiiiii	CI	8507 Myersville Ro				Midd	lleto	wn			Fre	der	ick	
	Funeral		5. Social Security Number 6. Sex	M 2DE	st birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	Month, Da	ay, Year,			ice (State or	Foreign
	Director		216-46-3078 Usual Residence of Decedent	45	113.				A	ug. 4	, 19	60	Mary	yland	
	iryland ihow		10a. State 10b. County	10c. City,	Town or Lo	cation							100	d. Inside City	
	he Ma	Director	Maryland Frederi	lck Midd	Letowi		0-4-				10- 0	A'	2	1 🗌 Yes	
	with t		10e. Street and Number	د.		10f. Zip	217	760			_	tizen of What			
	death	Funeral	8507 Myersville Roa	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Deced			gin? (Speci	ify Yes or No		nited States 14. Race - American Indian, Black, White, etc.			
36	s after or Ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1 □ Yes 2			, 1 0010 111	oan, oto.,		Specify:			
21215-0036	72 hours after death with the Maryland Instural; or Hema 23a or 28e-f show diest Exacilier must be notified at	ed b	15. Decedent's Edu		16a. Dece	dent's Usua	I Occupa	tion			16b. K	(ind of Busine	Whi ss/Indu		
215	s within 72 ho jene. r then "natur for Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of wor DO NOT us	rk done di se retired)	uring most	t of working	1					
121			12 17. Father's Name (First, Middle, Last)		Owne	er/Ope			r'e Name /	First, Middle		ass Con	mpar	ny	
lanc	a tal	To Be	Charles J. Dodson								, Maider	r Surname)			
Maryland	s 1 and 2 should by f Health and Menta item 27 la markad othar treumatic a	-	19a. Informant's Name/Relationship (Ty	pe, Print)	Sarah Boone 19b. Mailing Address (Street and Number or Rural Route Number)							or Town, State	ө, <i>Zip С</i>	Code)	
	s 1 and 2 of Health a item 27 la othar tree		Leigh G. Dodson/ W		8507 ce of Dispo			le Ro	ad, M		_	MD 2			
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R	emoval from State	netery, crei	natory or or	ther place	1				ocation - City			
altin	구두라는		*4 □ Donation 5 □ Other (Specify) 21. Signal A 4 Funeral Service License			. Name an	d Address	of Facility	y			dletow	n,Ma	arylar	ıd
ñ	Department Department		Yournes (Stauller	S1	auffe 21 Or	er Fu	inera imtow	l Hom n Pik	e P. A e. Fre	l. eder	ick Ma	rvla	and 21	702
			23a. Part T. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.	Do not ent	er the mode	e of dying	, such as	cardiac or I	respiratory a	rrest,		li li	Approximate nterval Betwonset and Di	veen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	0/10/10/0	CARC	ころって	14							Mari	
	Examiner		f.	Due to (or as a conseque	ence or):										
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique	Due to (or as a conseque	ence of):										
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								-		
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit			1											
9	rtificat ng phy s as th	Physician/Medical	IF FEMALE:												
Вох	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand	leath 3	Ectopic pro						23d. Date of o	,		ear
o.	that the de led by the a detached t	nyslo	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ıın əL	Other (spe	ecity)								
S, D	res that igned by be deta	by PI	Part II. Other significant conditions cor	tributing to death but not result	ing in the u	nderlying ca	ause givei	n in Part I.		23e. Did t	obacco	use contribute	to the	cause of de	ath?
ord	w require been si should (ted								1 🗆 '	Yes 2	□No 3□	Probab	oly 4 Ur	nknown
Vital Records,	e las has	ompleted								24a. Was auto		24b. Were prior to death	to comp	y findings av	vailable use of
tal		e C	25. Was case referred to medicał					26. Place	of Death /	1 ☐ Yes Check only o	2 N No			No	
of Vi	d: 5	To B	examiner? 1 ☐ Yes 2 X No	lospital: 1 Inpatient 2 El	R/Outpatier	t 3 🗆 DO	A Other					6 □Other (S	pecify)		
		lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	M 28	8c. Injury Work	at ? es 2□f		d. Describe	how inju	ry occurred			
Division	or Attanding after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	ю, farm, str			65 Z [] I		f. Location (Street ar	nd Number or	Rural F	Route Numb	er,
Ö	in Line	Cert	4 Homicide determined	building, etc. (Specify)						City or To	wn, State	9)			
	To the Hospital or Attention 24 hours after deation 24 hours after deation to the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 29a. Certifying Phys 2 Medical Examin	sician: To the best of my knowledge. On the basis of examination	edge, death n and/or in	occurred avestigation,	at the time in my opi	e, date and inion, deat	d place, and h occurred	d due to the at the time,	cause(s date and) and manner d place, and d	as state	ed. ne cause(s)	
	o tha	Med	29b. Signature and title of certifier	and manner stated.		29c	. License	number			29d. Da	te signed (Mo	onth, Da	ıy, Year)	
	->-0		THE STATE OF THE S	MD		Ī	00	563	14		JUN	JE 12	, 20	006	
	15		30. Name and address of person who co	mpleted cause of death (Item 2	(Type,	Print)	I SC M	(N	2011	En = i	EDI	CK, N	AD:	2170	2
	Sta	to	BINDU GEORG 31. Date filed (Month, Day, Year)				N>0	17 DF	ive,	THE				21/02	
	Registi		JUN 1 3 200	32 Registrar's Signatu	40	W.									

	1. Da	Registrar ecedent's Name	e (First Middl	le. [ast]			Ce	ertifica	te of L	Death		2. Date of De	Reg. No. ath		2.0	f Death
an		argaret		16, Last)		Elain	۵		Frank			Month June	20	2006		
cal ier		acility Name (/		n, give s	treet and nu					Location of	of Death	0 01.0		unty of Deat		
lei		ashingt		-				Hage	ersto	own			Was	hingt	on	
		09-16-1		6. Sex 1 □	M 2∏ F	7. Age (In 8.	yrs. last birthda Yrs.	y) If Unde Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da March	y, Year)	Co	hplace (State untry) nsylva:	_
		I Residence of State	Decedent			100	. City, Town or	Location							10d. Inside (ity Limits
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rect	-	Street and Nu		Liigu	711	110	agersto		ip Code				10g. Citizer	n of What Co	ountry?	
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by Funeral Director	1	Marital Status Never Marr		rried	Armed F	2 📉 No ive	in U.S. 13	3. Was Dece If Yes, spe 1 \(\text{Yes} \)		ispanic Ori an, Mexican Specify:		ecify Yes or No Rican, etc.)		Race - Ame Black, White Decify:		
ed	-	7.22 17.130.134	15. Deceder			<u> </u>	16a. Dec	cedent's Usi	ual Occup	ation			16b. Kind	of Business/		
Completed	FI		cify only highe		completed) (1-4or 5+)	(Gir	ve kind of w . DO NOT	rork done d use retired	during mos d)	t of worki	ng				
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To Be (arry W.		, Last)								(First, Middle, Bridl		mame)		
_	19a.	. Informant's N	ame/Relations	ship (Typ	oe, Print)		19b. Ma	ifing Addres	ss (Street	and Numbe	er or Rura	I Route Numbe	er, City or T	own, State, 2	Zip Code)	
	Ro	nald T	. Fran	k/So	n					on Ci		Alexa				
		Method of Dis	•	3.□86	emoval from		b. Place of Dis cemetery, c	position (Na rematory or	ame of other plac	ce)	C	Date	20c. Local	tion - City or	Town, State	
		4 Donation			a	I	Rest Hav							stown,		
	21.	Signature of Fe	uneral Service	License	9e							st Have				
	-	3.1	hack	Su	m			TOOT	enns	yıvan	ia A	ve., Ha	igerst	own, N	D 217	4.2
		shock, or hea				caused the	death. Do not e	enter the mo	de of dyin	ng, such as	cardiac c	or respiratory a	rrest,		Approxim	te
	dise	nediate Cause ease or condition ulting in death)	art failure. Lis (Final on	at only on	Hyp	oxia (or as a cor	death. Do not e					or respiratory a	rrest,		Approxima Interval Be Onset and	ite tween
lical Examiner	Seq if an caus Caus that	nediate Cause ease or condition	art failure. Lis (Final on onditions, mmediate erlying ar	a b c	Hyp Due to	each line. oxia (or as a cor ge III (or as a cor						or respiratory a	rrest,		Interval Be	ite tween
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State of Maryland / Department of H	lealth and Mental Hygiene 2 🛭 🖰 🗧 2 (

		1 - For State Registrar				artment of He tificate of D		Reg	j. No.	0 2020
Physic	ian	Decedent's Name (First, Middle,	,					2. Date of Death Month	Day Yea	3. Time of Death
/Med			va Frazi					June	10 200	06 9:45 a.
Exami	ner	4a. Facility Name (If not institution, g		nber)		4b. City, Town, or I	Location of Death		4c. County of De	ath
		Homestead M				Dento			Caro]	
Funeral			.Sex 1 □ M 2 🔀 F	7. Age (In yrs. last	- 11	It Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. 8	irthplace (State or Foreig Country)
Director		217–30–8592		106	Yrs.			March 28		Maryland
*		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	cation				10d. Inside City Limit
e g	ŏ	MD Carol:	i ne	,	0 1111 01 20		nton			1 ¥Yes 2 N
28a-	Director	10e. Street and Number						-		
E o	ă					10f. Zip Code		10g	. Citizen of What (Country?
ms 23a or 28a-f show	Funeral	410 Colonial I					21629		USA	
tte m	E C	11. Marital Status		dent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
5	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	9	1	☐ Yes 2 No	Specify:		Specify: W	hite
lural al E		15. Decedent's	Year or Da							
e a	Completed	(Specify only highest			Give	lent's Usual Occupat kind of work done du DO NOT use retired)	ion Iring most of work	ing 16	b. Kind of Busines	s/Industry
than	를	Elementary/Secondary (0-12)	College (1	-4or 5+)	me. L	homemak			1	
r. Per		17. Father's Name (First, Middle, La	et)					- (First 16'dat) - 14	own ho	ome
ad of	Be		•					e (First, Middle, Ma	•	
Merke	2	John Humphrey						ı Elizabet		
portion. Tages I strike a should be mad maint 72 modes and began that he mad year. Department of Health and Mental Hydiene. Important: If time 27 is marked other than "natural; or thems 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		19a. Informant's Name/Relationship				g Address (Street ar				Zip Code)
m 27		Carol Pritchett	grandda	ughter	2013	Church Cr	eek Road	, Cambrid	dge, MD	21613
f ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from 9	00000	of Dispos etery, crem	sition (Name of natory or other place,)	Date 20	c. Location - City o	r Town, State
ant:		`4 □Donation 5 □ Other (Spe		Dorch	ester	: Memorial	Park 6	5/13/06	Cambridg	e, MD
Departr Importa any inj once.		21. Signature of Funeral Service Lic	ensee		22.	Name and Address	of Facility T	homas Fun		
8 = 2		B-KB			1 7	00 Locust				
/Medical xamine-transit per price in the pri	edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consequence	دسان کاره	und e	Hocks			
y the attending pached for use as f	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	1□Live bi	come of pregnancy rth 2 Fetal dea ant at time ot death wn		Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
en signed b	ρ	Part II. Other significant conditions	contributing to de	ath but not resulting	g in the un	derlying cause given	in Part I.	23e. Did tobac	1.	o the cause of death?
ate has be page 2 sh	Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s
ctor,	Be (25. Was case reterred to medical examiner?				2	26. Place of Death	(Check only one)		
nis ce dire	To	1 Yes 2 No	Hospital: 1 ☐ In	patient 2 ER/	Outpatient	04		me 5 Residence	e 6 Other (Spe	Assisted
death. ctor: After th / the tuneral	Certification;									
= 0 A	-	4 Homicide determine	buildin	g, etc. (Specify)	lge death	Occurred at the time	date and place	City or Town, S	(ate)	a stated
nours afte meral Dir tilled in I	613	(Check only 2 Medical Ex-	aminer: On the ba	sis of examination.	and/or inve	estigation, in my opin	ion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
24 hours afte Funeral Dir etely tilled in t	dica	G/10)								
ithin 24 hours afte of the Funeral Direction of the Funeral Direction of the Funeral Direction of the full of the funeral of the full of the funeral of the full of the funeral of the fun	Medical	,				29C, License n	lumber	1 304	Data signad /4/am	th Day Von-1
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Medica	29b. Signature and title ot certifier		1	CH	29c. License r			Date signed (Mon	
within 24 hours afte To the Funeral Dir. completely tilled in t	Medica	29b. Signature and title of certifier			_	000	53255		Date signed (Moni	
within 24 hours afte To the Funeral Dir. completely tilled in t	Medica	,	o completed cause	of death (Item 23a	a) (Type P	DOC:	53255	-	10/12/	06

			For State Registrar	State of M	laryland		artment of H				giene 2	006	20201
			1. Decedent's Name (First, Middle,	Last)						2. Date of De.	ath Day	Year	3. Time of Death
	Physicia /Medic		Thomas M. Flir	t						June	8, 2006		9:45 P M
Ĺ	Examin		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of	of Death		4c. Coun	ty of Death	
			Collingswood N 5. Social Security Number 6	ursing Home	e ge (In yrs. las	st hirthday)	Rockv:		24 Hrs.	8. Date of Birt		ntgom	ery
	Funeral Director		579-32-0837	1 X 1M 2□F	78	Yrs.	Months Days	Hours	Min.	(Month, Da Jan 12	y, Year)		place (State or Foreign ntry) hington, DC
	D		Usual Residence of Decedent							Jun 12			
	arytan show	_	10a. State 10b. County			Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	be Mark	Directo	Maryland Mont 10e. Street and Number	gomery	Roc	kvi11	e 10f. Zip Code				10g. Citizen of	What Cou	
	with tale or 2				"	_		. .				Wilat Cod	inty:
	death ms 23	Funeral	14421 Traville	12. Was Deceden	t Ever in U.S.	. 13.	208. Was Decedent of H If Yes, specify Cub		igin? (Spe	ecify Yes or No	USA - 14. Ra	ce - Ameri	
ဖ	after or iter	Fur	1 Never Married 2 Marrie	Armed Forces d 1 TYPs 2 T	? !N ! 946 -	. !	If Yes, specify Cub 1 ☐ Yes 2 ☐ X No			Hican, etc.)	Spec	ack, White,	etc.
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<u> </u>	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show to Nedical Ezani ar must be notified at	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	t of worki	ng	16b. Kind of	Business/In	dustry
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<u>5</u>	Hygie other ent, t	Be C	17. Father's Name (First, Middle, L.	ast)			cijopcia		er's Name	(First, Middle,			its beare
lan	ould be Mental arkad o	To B	Thomas Hines H	lint				Fran	nces	Eleano	r Leonh	ardt_	
Maryland	and and ls m		19a. Informant's Name/Relationshi	p (Type, Print)	1	19b. Maili	ng Address (Street	and Numbe	er or Rura	I Route Numbe	er, City or Tow	n, State, Zip	code)
-	1 and 2 Health Iem 27 other tri		Stephen Flint/	Son	DON DIA	1413	Bernerd	P1, I		ille, l			
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		e cer	metery, cre	osition (Name of matory or other pla	'			20c. Location		
Ħ.	permit. Pages Department of Important: If it any injury or once.		 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L. 		Par		Memoria Name and Addre			and the second second second			
Bal	permit. Departr Importa any inji		21. Signature of Puneral Service C	T work of	00								g, MD 20904
Ė	_		23a. Part1. Enter the disease, or	omplications that cause	ed the death.								Approximate Interval Between
	Pnysician		shock, or heart failure. List of Immediate Cause (Final	no one cause on each	Y I	St.	· Her	te	_	1/			Onset and Death
1	/Medical		disease or condition resulting in death)	a Due to (or a	s a conseque	ence of):	· I (Car	T	cu	en v			3 MERCINS
	Examiner		Sequentially list conditions	ьС		ary	Arter	7 d	NSC.	rze.			
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):							
	and errans	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a conseque	ence of):							
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687	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical		d									
Вох	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			⊒Ectopic pregnanc	N/				ate of deliv	
B	deat ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant			Other (specify)		-		, N	lonth	Day Year
P.O.	that the death	Phy	9 Unknown		But not recult	*i== i= **== .		una ia Dani I		220 Did t	obassa usa sa	otribute lo t	he cause of death?
	6 50	by	Part II. Other significant condition	1 6 1		Ash Cha	anderlying cadse gr	S -	i.	1 🗆 1		3 Proi	
Ö	w require been si should b	Completed	- CALOANCE	Obstruct	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 0013			24a. Was	an 24h	Ware auto	opsy findings available
Rec	The law te has	ldm								autor	rmed?	prior to co death?	empletion of cause of
<u>a</u>	sician: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Place	e of Death	1 Yes	2 No	1 🗆 Yes	2 No
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	tient 2 E	R/Outpatie	nt 3 DOA			me 5 Resi		ther (Specia	fy)
0	ding Ph h. After thi funeral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of In	jury Jay Year)	28b. Time o	of 28c. Inju			28d. Describe			
Siol	Attending r death. ector: After y the fune	catic	2 Accident investig	ation			M 1]Yes 2□	-				
Division of Vital Records,	l or Attendatter death Director:	ertification:	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, st	reet, factory, office			28f. Location (City or To		nber or Huri	al Route Number,
	Hospital 24 hours a Funeral i	O	29a. Certifier 1 Certifying	Physicien: To the bes	st of my know	/ledge, dear	th occurred at the ti	ime, date ar	nd place.	and due to the	cause(s) and r	nanner as s	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical E	xaminer: On the basis and manner:	of examination	on and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time,	date and place	, and due t	o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	-	Ν.Δ	0	29c. Licen	se number			29d. Date sign	ed (Month,	Day, Year)
•	1		1 90 FISCH	1430 m	IA,		200	0624	735		Jun	e 9,	2006
	>		30. Name and address of person v	who completed cause of	death (Item	23a) (Type	Print) Or- +	5 0	2	ckuill	e MI) 70	850
	CA	ata.	31. Date filed (Month, Day, Year)	1>4 4400	trar's Signatu	1v(EC	ucz corle	VOV	100	CICULIT	1		V =
	Sta Regist	ate rar	JUN 12	who completed cause of 1SA 4430	yes &	14 19	partie						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:57PM JUNG 2006 Harry Arthur Garvin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County

9. Birthplace (State or Foreign Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 3 1915 Age (In yrs. last birthday) 10XM 2□ F Days Yrs. 90 Nov Maryland 579-12-0659 Usual Residence of Dece 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tv Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1062 Matthew Court 21742 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Railroad Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Clarence Garvin Virginia Armstrong Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Ann Ashby (daughter) 877 Showers Lane Martinsburg West Virginia 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Luke's Cemetery 6-16-06 Brownsville Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service License 1331 Eastern Blvd. N. Hagerstown Maryland 21742 'auxa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dirbeter Mellitus 1 Yes 2 No 3 Probably 4 Unknown Hylowtenion 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Gran Artury disease. 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No -31-06 2 Accident out of bed Unknown 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Hagerstown nursing Home

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. Hospitel or Attending Physicien: **Physician**

/Medical

Examiner

Directo

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Be Completed

Funeral

Director

item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Peges 1 and 2 should be filed withinent of Health and Mental Hygiene. ant: if Item 27 Ie marked other the:

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Physician /Medical Examiner

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Director: After th

within 24 hours eff To the Funeral Di completely filled in

death.

Examiner

Physician/Medical

Certification: To Be Completed

Medical

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JH-4

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and (it)

29a. Certifier



29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mynner stated.

D0062223

29d. Date signed (Month, Day, Year) 6/12/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAVEEN BILARUM, MO, 340-MILL STREET, HO - 21740

32. Registrar's Signature

			For 1 = State Registrar	State of	of Maryla		artment rtificate			ind Me	ental Hy	giene Reg. No	400	6	20203
	Dhuaiai		1. Decedent's Name (First, Middle	, Last)							2. Date of De	aath Da	y Yea		3. Time of Death
	Physici /Medio		Charles Louis	Gregan							June 1	12, 2	2006		3:00 A M
}	Examin	er	4a. Facility Name (If not institution Casey House	, give street and nu	mber)		4b. City, Rockv		Location of	f Death		- 1	County of Do		
	Funeral		5. Social Security Number	6. Sex 1 ፟ M 2 ☐ F	7. Age (In yrs	. last birthday	If Under Months	1 Year Days	If Under 2	24 Hrs.	8. Date of Bi (Month, D	rth av. Year)	9. 8	Birthplac Country	e (State or Foreign
	Director		183-22-4048 Usual Residence of Decedent	IZIM ZUF		74 Yrs.		,			Aug 1	193	31 Nev	√ Jé	rsey
	land ow		10a. State 10b. County		10c. C	ity, Town or L	ocation							10d.	. Inside City Limits
	Man Heth	ţ	Maryland Montgo	mery	Roc	kville									1X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Country	?
	ath wi		1415 Stratton D				208					USA			
	er de	Funeral	11. Marital Status	Armed Fe		J.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican,	jin? (Spec , Puerto R	cify Yes or No lican, etc.)	0-	14. Race - Al Black, W		
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ğ	2 hou	ted	15. Decedent	's Education	1948	16a. Dece	dent's Usua	I Occupa	ation		_	16b. K	ind of Busine	ss/Indus	stry
2	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	b kind of wor DO NOT us	e retired,)	or workin	g				
2	be filed within 72 hours after death with the Maryland ital Hygiene. dother then "natural", or itema 23a or 28a-f ehow event, the Madical Examinar must be notified at	Con	47 Fall of New (Cont. 18 date			Electi	rical	Engi					space		
Maryland 21215-0036	ntal H	Be	17. Father's Name (First, Middle,	Last)					Alma		(First, Middle	, Maiden	Sumame)		
Ž	should nd Me mark matic	၉	Joseph Gregan 19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mail	ina Address	(Street a				er City o	or Town, State	Zin Co	nde)
	nd 2 ; lith ar 27 is r treu		Janet Gregan/wi	fe									20854		,
altimore,	s 1 a of Hea itam cothe		20a. Method of Disposition	- 7	1	Place of Disp cemetery, cre	osition (Nam	ne of ther place	g)	Da	ite	20c. Lo	ocation - City	or Town	, State
Ĕ	Page nent cant. If ant: If ury or		t □ Burial 2 □Xremation 4 □ Donation 5 □ Other (Sp		Ch	esapeal			· 1	06/13	/06	Belt	sville	, Ma	aryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itema 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at ODGs.		21. Signature of Funeral Service	He III	MO1	251 B	2. Name and Ding H	d Addres lome	Crema Heckr	tion	Servi	ce Cla	P.O. E	ox 1e	784 MD 21029
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea									Aı	oproximate terval Between
1	Physician		Immediate Cause (Final disease or condition	Conge	stive	Heart 1	Failur	·e							nset and Death
N.	/Medical Examiner		resulting in death)		(or as a conse										
	LAGITITIE	_	Sequentially list conditions,	b	for as a cons	turnet of									
	ted	Examiner	Sequentially list conditions, tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- Ode to	(or as a conse	quenue ou									
<u>,</u>	execun and and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):								1	
8760,	icate be executed physicien and s the burial-transit	dicai		d											
ဖ	ng ph	0	IF FEMALE:												
õ	eth ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live I	tcome of pregn pirth 2 Pet	el death 3[□Ectopic pre						23d. Date of o	delivery Da	y Year
Division of Vital Records, P.O. Box	The law requires that the deeth certifi ite hes been signed by the ettending I age 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregi 9□Unkn	nant at time of own	death 5{	Other (spe	ecify)					WORL	Ua	y 1941
۳.	that I		Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	inderlying ca	use give	n in Part I.		23e. Did 1	obacco u	ise contribute	to the	ause of death?
rds	quires nn signi uld be	ed by									10	Yes 2	Zmo 3□	Probabl	y 4 Unknown
ပ္သ	aw requires s been si 2 should b	piet									24a. Was		24b. Were	autopsy	findings available
m m		Completed									auto perfo	rmed?	death	o compi	etion of cause of
<u> </u>	Attending Physicien: The death. c death. ector: After this certificete by the funeral director, pag	Bec	25. Was case referred to medical examiner?							of Death	Check only				
5	tending Physicien: leath. tor: After this certific the funeral director,	၉	1 ☐ Yes 2X No			ER/Outpatie			4 🗀 (40):				6 Other (S	pecify)	hospice
u C	ding P. After funer	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	9	of Injury th, Day Year)	28b. Time of Injury	of 28	Bc. Injury Work	at ? ′es 2⊡N		3d. Describe	how injur	y occurred		
<u>isi</u>	l or Attendente offer deatl	ficat	2 Accident investig	ot be	of Injury - At h	nome, farm, st			65 2 11		3f. Location (Street an	d Number or	Rural Re	oute Number
Š	al or / s effer if Dire	Certification:	4 Homicide	build	ing, etc. (Spec	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or To	wn, State)		50.5 (0.11.50),
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai (29a. Certifier (Check only one) Certifyin 2 Medical I	g Physician: To the Exeminer: On the b and man	best of my kn asis of examin ner stated.	owledge, deal ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, death	place, an	d due to the	cause(s) date and	and manner I place, and d	as state ue to the	d. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. -		~ ~		License				29d. Dat	e signed (Mo	nth, Day	/, Year)
			1	1	/	10	D	3563	35			June	12, 2	006	
ok')00		30. Name and address of person Joseph Kaplan,	M.D. 6001	Munca	ster M	ill Rd	. Ro	ckvil	le,	MD 208	55			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1	4 2006	Registrar's Sign	ature	Sno. N			-					
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year JUNE 05, STEPHEN GOGNIAT 2006 8:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2∏ F 206.07.2403 87 Director JANUARY 8, 1919 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at Director MARYLAND MONTGOMERY BROOKEVILLE 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19117 MOUNT AIREY ROAD 20833 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other then "naturel", or item in jury or other traumatic event, the Medical Examina Date. 1 X Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ WWTT WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 5+ PETROLEUM ENGINEER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NICHOLAS GOGNIAT MARY DANYLIK ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE GOGNIAT / WIFE 19117 MOUNT AIREY ROAD, BROOKEVILLE, MARYLAND 20833 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ST.JOHN THE BAPTIST UKRAINIAN 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State JUNE 10,2006 TITTSBURGH, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) CATHOLIC CHURCH CEMETERY 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licenses Nan 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of) Examiner CHRONIC LYMPHOCYTIC LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examiner The law requires that the death certificate be executed iding physician and se as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MYOCARDIAL INFARCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No RENAL FAILURE 24a. Was an has autopsy performed page certificate MULTIORGAN SYSTEM FAILURE 2XI No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death.

Director: Af
d in by the fur investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral I To the Hospitai 29a. Certifier Medical 1 🔯 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check out

P.0. Division of Vital Records,

> State Registrar

29b Signature and title of confiller

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

ROBERT DAVID KIRKCALDY, M.D., 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

32. Registrar's Signature

Staller.

nd address of serson who completed cause of death (ftem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JUNE 05, 2006

D0061681

		_	1- For State of Maryland / Department of Health ar Certificate of Death		Reg. No.	20205
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) PROSPER RICHARD GAGNE	2. Date of D JUNE	Day Year	10.27 DM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death	4c. County of De	ath
			19720 MOUTH OF MONOCACY RD. DICKERSON 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs. 8. Date of B	MONTG	OMERY inthplace (State or Foreign
	Funeral Director		363-22-1958 12 M 2 F 80 Yrs. Months Days Hours		26 1925	WI
	P		Usual Residence of Decedent			Tana Inside Challing
	laryla shov	'n	MI OAKLAND 10c. City, Town or Location ROCHESTER HILLS			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	the N	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Whaf C	1
	3a or	io is	1418 BRIANS WAY 48307		USA	•
	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. Hylgiene. do ther then "neturel", or tems 23a or 28a-f show do ther then "neturel", or temperative reset to recitified at event, the Madical Examinar reset to recitified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amgd Forces? 1 Q A A II Yes, specify Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	14. Race - Arr Black, Wh	
36	rs afte	by Fu	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Neve		Specify: W]	HITE
Ş	2 hour	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation		16b, Kind of Busines	
215	thin 7; e. en "n	Completed	(Specify only highest grade completed) [Give kind of work done during most of life. DO NOT use retired) [Ide. DO NOT use retired] [Ide. DO NOT use retired] [Ide. DO NOT use retired]	-		JSTRY
21	led wi lygien her th	Cou	PLASTIC LAMINATOR		GM	
_	m - 0 =	Be c		A DENOME	le, Maiden Sumame)	
Maryland 21215-0036	shoul	2	19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number BD A CT CHEVENIC / GRANDDAUGHTER	or Rural Route Num	ber, City or Town, State,	Zip Code) 20842
Ž	and 2 saith a n 27 li		19720 MOUTH OF M	MONOCACY	RD., DICI	KERSON, MD
altimore,	ges 1 t of Hi If iter or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cameter) containing place)	Date 116/2006	20c. Location - City of ROYAL OAI	
<u>=</u>	it. Pa irtmen irtent: njury		• 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility		ROYAL OAL	K, MI
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.		HILTON FUNERA P.O. BOX 86,		TITE MD	20838
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory	arrest,	Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition CAUSESTIVE LEAT ALL	are		Onset and Death
	/Medical Examiner		resulting in death) ue turn as a consequence of):	20		
	李	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	58		
	cuted nd ransit	Examiner	that initiated events			11
8760,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last Due to (or as a consequence of):			
687	ate hy:	edicai	d			
Box (death certifica attending ph of for use as t	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feltal death 3 □ Ectopic pregnancy		23d. Date of de	
	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Month	Day Year
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Vital Records,	quires tha n signed l	d by		1]Yes 2⊠No 3□F	Probably 4 DUnknown
CO	aw requir is been si 2 shoułd	Completed		24a. Wa	s an 24b. Were a	utopsy findings available completion of cause of
Ä		Com		per 1 □ Yes	formed? death?	1/
Vita	Physicien: The lar this certificate has ral director, page 2	Be	examiner?	of Death (Check only		NDDAUGHTER '
o	Phys	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	sing Home 5 Res	sidence 6 ther sp how injury occurred	HOUSE
ion	ttending death. stor: Afte	atior	1 XNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	0		
Division	l or Attending after death. Director: After I in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or F own, State)	Rural Route Number,
	e Hospitel of 24 hours at e Funerel Dietely filled i		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to the	e cause(s) and manner a	s stated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.			
	To the within 2 To the complet	M	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	oth, Day, Year)
			raturcia lomster lagilla		June 10	12006
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	B-100.	Rockvii	/e MD20852
	Sta		31. Date filed (Month, Day, Year) JUN 1 3 2006 32. Rejstrar's Signature	1 100/	/ - / /	
	Registi	ar	JUN 1 3 2006 Jane & Specie			

			1 - For State Registrar	State of Maryland		artment of H			giene 20	06	20206
	Physici		1. Decedent's Name (First, Middle, Last) JOSE LUI	S		HERN	ANDEZ	2. Date of De Month June	ath Day	Year OD6	3. Time of Death 03:52 A M
*	/Medio Examin		4a. Facility Name (If not institution, give si) (4b. City, Town, or	Location of Dea		4c. County		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ly, Year) 1963	9. Birthpla Country	
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					d. Inside City Limits
	8a-fat	Director	Maryland Montgome	ery Silve	er Spr						1 Tyes 2 No
	with the	Dir	10e. Street and Number 11216 Legato Way			10f. Zip Code 20901			10g. Citizen of W USA	Vhat Country	y?
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I and Mental Hygiene. I americed ther than "naturat", or items 23a or 28a-f ahow armatic avant, the Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue Specify:Cub	rto Rican, etc.)	14. Race Blace	e Americar k, White, et	C.
12-0	n 72 hou "natura edical E	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired.	luring most of wi	orking	16b. Kind of Bu	siness/Indu	stry
212	d withing giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+) 4		inistrati		stant	SMS Data	Produc	ts Group
Maryland 21215-0036	id be filed v ental Hygie ked other i ic avant, iii	To Be (17. Father's Name (First, Middle, Last) Juan A. Hernandez					ame <i>(First, Middl</i> e, Rodrigue		e)	
lary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Typ	ee, Print)	19b. Mailin	g Address (Street a	and Number or F	Rural Route Numb	er, City or Town,	State, Zip C	Code)
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic at once.		Juan A. Hernandez 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pla emoval from State	ace of Dispo metery, cren	6 Lejato sition (Name of natory or other place n Crematory	^{g)} Ju	ne 12,	20c. Location -	City or Tow	n, State
Baltii	Department Popularity Importarity Popularity		21. Signature of Funeral Service License		Fr	Name and Addres ancis J. O Univers	scf Facility Collins	Funeral		nc.	
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	eations that caused the death. e cause on each line. GASTROINTES				ac or respiratory a	rrest,	lr C	Approximate Interval Between Onset and Death OMINUTES
	/Medical Examiner		resulting in death)	Due to (or as a consequence of STEMIC L	,	ERYTHEN	1 A Tous			30	DYEARS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence NoN - ST EL	ence of):	ON MYOC.	HIZDIAL	INFARCTI	02	2	WEEKS
8760,	icate be executed physicien and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a conseque						15	TYEARS
Box 6	ne death certif the attending thed for use as	by Physician/Med	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery	ay Year
ds, P.	uires that the signed by the detaction		Part II. Other significant conditions cont	ributing to death but not resul	lting in the ur	nderlying cause give	nn in Part I.	23e. Did t	obacco use contri		cause of death?
Vital Records, P.O.	The law requir sete has been si page 2 should I	Completed						24a. Was autor perfo 1 Yes	rmeg? a	Vere autops rior to comp eath?	y findings available pletion of cause of
/ita	ysician: This certificete	Be	25. Was case referred to medical examiner?	ospital: 🖼	17:05:	100		eath (Check only o			
Division of	ding Phys n. After this funeral di	ation; To	1 Yes 2 No No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	129Inpatient 2 ∐ E	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 🔲 Nursing	Home 5 Resid	dence 6 Othe		
Divis	in the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	ar or Rural P	Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Direct completely filled in the	Medical ((Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place sinion, death occ	e, and due to the curred at the time,	cause(s) and mar date and place, a	nner as state and due to th	ed. ne cause(s)
)	To I	Σ	29b. Signature and title of certifier MED	ICAL DOCTOR	2	29c. License	number 5 - 000		29d. Date signed JUNE 1		•
	>		30. Name and address of person who cor OLCAY AKSY, THE JOH	npleted cause of death (Item	23a) (Type, i+oSPi	Print) TAL, 600 1	NORTH I	wolft ST	TREET BA	ALTIMO	RE MD
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	anti					

			For State Registrer	ate of Maryland		artment of H		Re	g. No.	20207
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	
	Physicia /Medic			HERSHMAN				June 1	2, 2006	0250 M
	Examin	er	4a. Facility Name (If not institution, give stree				Location of Death		4c. County of De	
			Garrett County Me	MOTIAL HO	-	1 Oakl		8. Date of Birth	Garre	Lt irthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1		Yrs.	Months Days	Hours Min.	(Month, Day, 9 / 20 / 1	Year) (Country)
_			Usual Residence of Decedent	, 3				3/20/1	J J 1 1 11	V
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fal	cto	WV Preston	Te	rra A	lta				1 ☐ Yes 2 XNo
	라 다 or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	ath w	la	RR 2 Box 5-B	No December 5 to 116	3 40.3	26764		noity Von ar No	U.S.	nerican Indian,
õ	y within 72 hours after death with the Maryland jiene. Than "neturel; or Items 23a or 28a-f show Itte Madical Examiner must be notified at	y Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in U.S trmed Forces? □ Yes 2 M2 No f Yes, Give ∕ear or Dates:		was Decement of h f Yes, specify Cuba 1 ☐ Yes 21/2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
5-003p	hours urel',	d by			16a Docor	dent's Usual Occup	ation	1	6b. Kind of Busines	
γ̈	within 72 ene. then "net he Medica	Completed	15. Decedent's Educatio (Specify only highest grade cor	npleted)	(Give	kind of work done of the contract of the contr	during most of worki	ing	ob. Kind of basines	amoustry
121	withi ene. than	щo	Elementary/Secondary (0-12)	College (1-4or 5+)			erapy as	1	t Heal	Lth
O O	E P E	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
a	Aental Mental rked o	To B	Arthur Davis				Evelyn	M. Sar	son Davi	is
2	short and a man		19a. Informant's Name/Relationship (Type, F		19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State	, Zip Code)
	1 and 2 Health a em 27 ls		Carl E. Hershman			197-97	B, Terra	The second secon		5764
altimore,	Pages 1 nent of He ent: If iten ury or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	ce	metery, crer	sition (Name of matory or other place ta Ceme			Oc. Location · City of Terra A	
Balti	permil. Pages Department of I Importent: If its any injury or o		21. Signature of Juneral Service Licensee	Speak	A 1	Name and Addre	ss of Facility Wright 1and Ave	Funera	al Home ra Alta	. WV 26764
			23a. Part1. Ententhe disease, or complication shock, or heart failure. List only one care	ons that caused the death						Approximate Interval Between
J.	Pnysician		Immediate Cause (Final	/ s/			2			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	en of):	evan	4			7 - 7
	Examiner		D	Par Kin	802	-3				6-05
	n =	ē	Sequentially list conditions, 1 my loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					2
	nd ransi	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last							
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ence ot):					
8760	icate b physic s the b	dlcal	d							
9 ×	.≡ O .a	Physician/Me	IF FEMALE: 23c. I	f yes, outcome of pregnar	nev				23d. Date of d	elivery
Box	that the death cer ed by the attendir detached for use	clan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	′		Month	Day Year
о <u>.</u>		ysl		Dunknown		, , , , , ,				
	that hed b	by Pi	Part II. Other significant conditions contribu	uting to death but not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires that been signed be should be det	Q D	_ Bustric	A.				1 ☐ Yes	s 2□No 3□	Probably 4 Munknown
Division of Vital Records,	B 8 C	Completed						24a. Was an autopsy perform	ed? prior to	autopsy findings available completion of cause of
a	icien: Th certificate rector, pag	ပ္ပ	25. Was case referred to medical				26. Place of Deatl			es 2 No
Ē	Attending Physicien: ir death. ector: After this certifics by the funeral director, I	O B	examiner? 1 Yes 2 No	ital: 1 Inpatient 2 1	ER/Outpatier	nt 3□ DOA Oth	ar		nce 6 ∐Other (Sp	pecify)
ō	Physer this eral di	 	27. Manual of Death 2		28b. Time o		y at	28d. Describe hov		
<u>o</u>	Ntending I death. ctor: After y the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Tour)	injury		Yes 2 □ No			
Divis	l or Attendater death Director:	Certification;	3 Suicide 6 Could not be determined 2	 Place of Injury - At ho building, etc. (Specify 	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ht completely filled in by the funeral director, page	edical C	(Check only 2 Medicel Exeminer:	on: To the best of my know On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the car ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licens	e number		d. Date signed (Mo.	nth, Day, Year)
	->-0		1/ the	TONA	rt	~ DL	12410	4	6/16/06	
			30. Name and address of person who compl	eted cause of death (Item	23а) (Туре,	Print)				
_			Savopoulos, Sotie			cth 4th S	treet, Oa	kland, M	D	
	Sta Regist	ate rar	31. Date filed (Month, Daw Year) 6 200	32. Registrar's Signat	ture	Society of				

06-04231 John Holland

Please Type or Print in Black Indelible Ink State of Wardand Persattment of Realth and Mental Hygiene

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iii i iolialia		- For State Certificate Registrar	of Death	Reg. No.	16 2020
Physician	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death 1329 hrs
ledical Examin		John Philip Holland, Jr.	Lucia Taranta (Darib	June 18, 2006 4c. County of Deal	
	1	4a. Facility Name (if not institution, give street and number) 1401 Blair Mill Road	4b. City, Town, or Location of Death Silver Spring	Montgomery	
	4			8. Date of Birth (MM/DD/YYYY) 9. Bi	irthplace (State or
Funeral Director		223-66-4509 1xm 2F 56	Yrs. Months Days Hours Min.	- TEoroi	
any		Usual Residence of Decedent 10a. State	ocation		10d. Inside City Limits
*	_ ,	Manual and Mantagements Silver	Spring		1 Yes 2 X No
Maryland 28a-f show 1 at once.	윉	Maryland Montgomery Silve:	10f. Zip Code	10g. Citizen of What Cou	untry?
ith the Maryland 23a or 28a-f shov	Director	8527 Second Avenue	20910	USA	
with ns 23.	- L	11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Spill of Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Ame	rican Indian, Black,
death or iten	<u>.</u>	Never Married 2 X Married 1 X Yes 2 No			
after	ğ-	or Dates: 974	Yes 2 X No specify: edent's Usual Occupation (Give kind of w		nite
hours			ng most of working life. DO NOT use retir		industry
36 in 72 han	ompleted		communications Spe	ofolian Endomal C	
d with	탉	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surname)	overnment
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	John Philip Holland, Sr.	Margare Iailing Address (Street and Number or R	t Elizabeth Delan	ev
21. ould b J Men S mar	힑	19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or R	ural Route Number, City or Town, Stat	te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once			27 Second Avenue S	ilver Spring Mary Date 120c. Location - City of	land 20910
re, slan of Hea If iter		crematory	isposition (Name of cemetery, or other place)	Date 200. Location - City o	or rown, state
imo Page nent c ant: or oth		4 Donation 5 Other Specify:	Crematory Jun	.20.2006 Alexandr	ia.Virginia
Baltimore, permit. Pages I a Department of He Important: If ite	- 1	21 Signature of Funeral Service Licensee	22 Name and Address of Facility Francis J. Collins	Funeral Home, Inc	c.
	- 1	23a. It I Enter the disease, or complications that caused the death. Do not e	500 University Blv	dWSilver Spri	Approximate Interval
Physician /Medical		fillure. List only one cause on each line.	Atherosclerotic C		Detween Onser and
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Sciencesis Due to (or as a consequence of):	nerelociciotic o	HULOVUSCULUL BIS	
1		Sequentially list conditions, b.			
	le	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Clisease or injury that initiated events resulting in death) Last			8
ruted nd transit		d			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X AMENDED ITEM#1,23a,27,	perME,G857,7/13/06 TT		
760, icate be exgraph sician the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna	23d. Date of deliver	ery Day Y ear
Sox 687 leath certific e attending for use as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Other (Specify)	ncy World	Day Teal
Box e death o the atter	Physician	1 Yes 2 No 9 Unknown 9 Unknown			
that the d	<u>P</u>	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobacco use contribute t	
signe 1 be de	d by			1 Yes 2 No 3 Pr	Sample of the House of
ords, w requir s been s should l	Completed			autopsy prior to	autopsy findings available completion of cause of
Reco	mo			performed? death?	promote and the second
ital Redician: The scerificate	BeC	25 Was case referred to medical examiner?	26.Place of Death (Check		
Division of Vital Records, tal or attending Physician: The law requir is after death. al Director: After this certificate has been seen by the funeral director, page 2 should	TO E	1 Yes 2 No Inpatient 2 ER/Out		g Home 5 Residence 6 Oth 28d Describe how injury occurred	er: Scene
1 of Ving Phy.		(Month, Day, Year)	ne of Injury 28c. Injury at Work?	28d Describe flow injury occurred	
Sior Attend death sctor:	cati	2 Accident Investigation	n, street, factory, office building, etc.	28f. Location (Street and Number or F	Rural Route Number City
Division ospital or Attent hours after death ineral Director:	Certification:	3 Suicide Could not be determined (Specify)	i, stroot, rustory, omes sanding, sta	or Town, State)	
Divospital ospital of uneral Civilled		29a Certifier 1 Certifying Physician: To the best of my knowledge death	occurred at the time, date and place, and	due to the cause(s) and manner as st	arted.
To the Hospital within 24 hours To the Funeral completely fille	Medical	one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred a	at the time, date and place, and due to	the cause(s)
To To	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (N	fonth, Day, Year)
		1 and "	O.C.M.E.	June 19, 2006	
		30. Name and address of person who completed cause of death (Item 23a)			
10+1	9	Ana Rubio MD. Assistant Medical Examiner 111 P.	enn Street, Baltimore, MD 2120	1 	83
Si Regis	tate	6 MACHEN / 1 / 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Anole		
			THE ALE		

			For State Registrar	Sta	ate of Ma	ryland / [Departme <i>Certifica</i>	nt of H	lealth ar Death	nd Mei		giene) Neg. No.	006	5 20	1209
7 7 7			1. Decedent's Name (First, Mic	idle, Last)						2.	Date of Dea	ith Day	Yea		e of Death
3.8	Physicia /Medic	_	Vance	Ν	Holm	es					JUNE	5,	2006	5	7:40P ^M
	Examin	30.1	4a. Facility Name (If not institu				4b. Cit	y, Town, o	r Location of I	Death			ounty of De		
		*		Adventi				koma ler 1 Year	Park If Under 24	Hre o	Date of Diet			George	
4	Funeral Director		5. Social Security Number 579 - 34 - 1031	6. Sex 1 [X] M 2		(In yrs. last bir 78	Yrs. Month			Min.	Date of Birth (Month, Day Feb. 1	4. 19	928 Wa	Country) SShingt	te or Foreign
	pus M		Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c. City, Tow	n or Location							10d, Insid	e City Limits
	Aaryla f sho	ō		nce Geo:	rges	Taliama	. David							1欠	Yes 2 □ No
	the t	Director	10e. Street and Number		1800	Takoma		Zip Code				10g. Citize	n of What	Country?	
	3a or		6735 New Ham	pshire				20912				Unit	C.		
	death	ner	11. Marital Status		as Decedent E	rer in U.S.	13. Was Dec	edent of H	lispanic Origin an, Mexican, F	n? (Specific	y Yes or No-	14	Race - An Black, W	ates nencan India	n,
9	after or ite	Fu	1 Never Married 2 N	Married 1 5	ZYes 2 □ No		1 ☐ Yes		Specify:		, 5, 5, 5,	s	pecify: B1		
21215-0036	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Examinat must be notified at	Completed by Funeral	3 ☐ Widowed 4 € Divord	ed Ye	ear or Dates 10	50-195		10							
15-	"nat	lete	(Specify only hig	dent's Education thest grade comp			Give kind of v life, DO NOT	vork done	durina most o	of working		16D. KING	f of Busines	ss/industry	
12	withi lene. than	mo	Elementary/Secondary (0-13		years)	Painter		•			Se1	f Emp	loyed	
p	illed Hyg other		17. Father's Name (First, Midd		- 10010		T W TITLE CT		18. Mother's	s Name (F	irst, Middle,				
lan	uld be Aenta rked tlc ev	To Be	Vance Holme	S				a my my data.	Agnes	s Gre	en				
Maryland	2 should be f and Mental h is marked of raumatic eve	•	19a. Informant's Name/Relation				. Mailing Addre					-			
Σ,	and and n 27		Gregory N.H) imes	(Son)	6	735 New	<i>i</i> Hamp	oshire	Ave.	#510F	Tak	oma P	ark, M	D 20912
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show among a proper traumatic event, the Michael Exemples must be notified an once.		20a. Method of Disposition 1 Derial 2 Corematic	on 3 □Remov	al from State	cemete	f Disposition (A ry, crematory o dale Pa	iame or r other plac	ce)	Date	9	20c. Loca	ation - City o	or Iown, Stat	е
ţ	rtant:		4 □Donation 5 □ Other 21. Signature of Funeral Serv			KIVCI					2/06		erdal	e, Mar	yıana
Ba	Depermination of the contract		21. Signature of Parietal Serv			\supset	3821	ThrRa 14th	syster Stree	Fune et NW	ral Ho Wash	me ningt	on, D	C 2001	1
			23a. Part1. Enter the disease shock, or heart failure.	or complication st only one cau	ise on each line).			-		espiratory ari	rest,		Approxi Interval	Between
	Physician		Immediate Cause (Final disease or condition	a.	Vent	ricula	in Ta	chy.	cardi	Ci)	ind Death
	/Medical Examiner		resulting in death)		Due to (or as a			,							
	LXdimiler	_	Sequentially list conditions,	b	Due to (or as a	consequence	of):							-	
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	D00 10 (01 03 0	consequence	01).								
	execunand and all-tra	Exar	that initiated events resulting in death) Last	c	Due to (or as a	consequence	of):			<u> </u>					
8760,	death certificate be executed e attending physician and id for use as the burial-transit														
9	tificate ng phys as the	Physician/Medical													
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		yes, outcome o		n 3⊡Ectopio	pregnancy	/			23	d. Date of d	-	Vana
	the at	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Pregnant at t □Unknown	me of death	5 Other	(specify) _					MOUTH	Day	Year
P.0	± > 5		Part II. Other significant cond	ditions contabut	ing to death bu	not resulting i	n the underlying	n cause div	ren in Part I		23e. Did to	ibacco use	e contribute	to the cause	of death?
g,	se og	1 by	Tarin Suisi Signing		ing to count ou			g oacoo gr				es 2 🗆			Unknown
Sor	w requir been si should	Completed			,						24a. Wasa	an l	24h Were	autopsy findir	age available
Rec	The lav ate has page 2	шb									autop	sy med?	prior to death	o completion?	of cause of
la		e Co	25. Was case referred to med	tical					26 Place o	of Dooth (1 ☐ Yes Check only o	No	1 ∐ Ye	es 2 No	
of Vital Records,	Physician: this certific ral director,	To B	examiner? 1 Yes 2 □ No	Hospita	al: 1 ☐ Inpatier	t 2 XER/Oi	utpatient 3	DOA Oth	0.00		5 Resid		Other (Sc	pecify)	
			27. Manner of Death		a. Date of Injury (Month, Day	28b.	Time of	28c. Injur Wor	y at		d. Describe h			,,	
ior	Attending Indeath: actor: After by the funer	atio	2 11,100,000	estigation	(M		Yes 2 □ No	0					
Division	after death after death Director:	ertification:		uld not be ermined 286	e. Place of Inju building, etc.	ry - At home, fa (Specify)	arm, street, fact	ory, office		28f	Location (S City or Tow		Number or	Rural Route I	Vumber,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical C	(Check only one)	fying Physician cal Examiner: C	on the basis of	examination ar	e, death occum nd/or investigati	ad at the tir on, in my o	na date and appinion, death	clace and	d due to the d at the time, o	date and p	nd rannel lace, and d	se etated ue to the cau	se(s)
	o the ithin 2 o the ymple	Med	29b. Signature and title of cer		nd manner stat	1		29c. Licens	e number	4		29d. Date	signed (Mo.	nth, Day, Yea	ar)
	F 3 F 8		James 1	1. Fish	tfor,	L M.D		57	232	.6		- /	/200	, ,	
7	3		30. Name indiaddress of per	son who complet	ted cause of de	ath (Item 23a)	(Type, Print)					-			
			DR. JAMES	, -	FOOT	76	00 CA	PRRO	11 AV	É	TAKO	MA	PARK	Md.	20912
	A Sta		31. Date filed (Month, Day, Y	ear)		's Signature	boath	9	1		.,,			7-1-1-	
	Regist	rar	JUN 1	2 2006	ETA BURE	1 55	March Bar								

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 200612:30PM **Physician** 04 UNF Catherine Hutchins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** 1 □ M 2**X** X= Yrs. 20, 98 1908 Washington, DC Director Mar. 219-34-4731 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County If item 27 is marked other than "neture!', or iteme 23a or 28a-1 ehow or other traumatic event, the Madical Examinar mast be notified at 1 Yes 2 No Anne Arundel Gambrills Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O. Box 734 21054 USA Funeral permit. Pages 1 and 2 should be filled within 72 hours after dea. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural" one on injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard V. Waters Sarah Ann Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Greer (Daughter) 1699 Millersville Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baldwin Mem. Cem. 6-8-2006 Millersville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final END STAGE DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hent 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 2 Accident investigation 24 hours after deat Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D57531 JUNE 05, 2006 MD 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Hwy, millersville, mp 21108 8601 Veterans moh NES 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

		For State Registrar	State of Man		partment of learning of the contract of the co		d Mental Hy	giene	06	20211		
Physicia		Decedent's Name (First, Middle, Last Shirle		Jones			June 1		Year	3. Time of Death 3:33 A M		
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. County	of Death			
LXamin	C.	Calvert Memoria	1 Hospital		Pri	nce Fre	derick	Ca	lver	t		
Funeral		Social Security Number 6. Se	x 7. Age (/	n yrs. last birthda	y) tf Under 1 Year	tf Under 24		th av Voar)	9. Birthi	place (State or Foreign		
Director		217–30–1082	☐M 2⊠F	71 Yrs.	Months Days	Hours	Jan 1,	1935		h. DC		
p >		Usual Residence of Decedent 10a. State 10b. County	14	Oc. City, Town or	Location				₇	10d. Inside City Limits		
anyla shov	-	MD Anne Ar		Lothia						1 ☐ Yes 2 🔀 No		
the M	Director	10e. Street and Number	uncer		10f. Zip Code			10g. Citizen of V	What Cour			
with a or	늅	6135 Fishers St	711		USA	шуг						
eath	era	11. Marital Status	12. Was Decedent Eve	er in U.S.			? (Specify Yes or No)- 14. Rac		can Indian,		
r Iten	Funerai	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X No				? (Specify Yes or No uerto Rican, etc.)	Blac	k, White,	etc.		
id Z IZ 13-0030 filed within 72 hours after death with the Maryland Hygiene Hygiene ther than "natural", or items 23a or 28a-f show ant, in e Marcical Examinet must be malified	þ	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:		Specify	: Wh:	ite		
natur	Completed	15. Decedent's Edi (Specify only highest grad	acation le completed)	16a. Dec	cedent's Usual Occu	pation during most of	f working	16b. Kind of Bu	siness/In	dustry		
thin ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done . DO NOT use retire	ed)						
led w lygier her th		12		He	ousewife	10 11-15-1-	Name (Final Adiabate		_Home	9		
II y Idliu Z I Z should be filed within nd Mental Hygiene. marked other than matic event, the M	Be	17. Father's Name (First, Middle, Last) Temple		Jenkins	=		Name (First, Middle bl e	, маюеп Sumam		ankins		
should not Men or marka	P.	19a. Informant's Name/Relationship (T.	una Print)				or Rural Route Numb	or City or Tour	-			
Mally and the		Lawrence Jones (h	•		-		n Road L	-		20711		
paritificates, invary failed x 1x 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelin and Menalta Hygiene. Importment if the m27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Marylan Examinet must be notified at once.		20a. Method of Disposition		20b. Place of Dis	position /Name of	_	une ^{Dat} 13	20c. Location -				
Pages nent of I		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,		Lee Cre	rematory or other pla	,	2006	Clint	on. I	νTD		
Dallillor permit. Pages Department of Importent: if it any Injury or o		21. Signature of Funeral Service Licens			22. Name and Addr		Lee Fune:					
Demi Depa Impo any Ir		Gary J. Go	FF	1	3125 South		ryland Bly			MD 20736		
SUPPLY I		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the				*			Approximate Interval Between		
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be is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury		nsequence of):	1							
and I-tran	хап	that initiated events resulting in death) Last	onsequence of):			UFine	7	-				
cate be executed physician and the burial-transit						1	nje ctuc	00				
ficate phys s the	edicai		d.			14						
n certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Dat	e of delive	delivery		
death death d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tim		B □Ectopic pregnand S □ Other (s <i>pecify)</i> _	у		Moi	nth	Day Year		
by the	hys	9 Unknown	9□ Unknown									
The Colds, F.C. BOX or The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying cause g	ven in Part I.	23e. Did	23e. Did tobacco use contribute to the cause of de				
w requires to been signed should be							_ 10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ur				
law ras be	Completed	24a. Was an autopsy prior to								psy findings available mpletion of cause of		
The tate h	Con	performed? death? 1 Yes 2 No 1 Yes 2 No										
VII.di icien: T certificat ector, pa	Be	25. Was case referred to medical examiner?	I lossitati				Death (Check only	one)				
Physic ruthis or ral dir	ပ္	1 Yes 2 No 27. Manner of Death	Hospitat: Inpatient 28a. Date of trijury	2 ER/Outpat	ent 3 DOA		ng Home 5 Resi	dence 6 Other		γ)		
ding h. After fune	tion	U Natural 5 ☐ Pending	(Month, Day Y	ear) Injun	/ Wo	ork?]Yes 2∐No	28d. Describe	now injury occurr	0 0			
DIVISION I or Attending after death. Director: Attellin by the fune	ertification;	3 Suicide 6 Could not be	28e. Place of Injury	· At home, farm,			28f. Location (Street and Number	er or Rura	l Route Number,		
after after din b	erti	4 Homicide	building, etc. (Specify)	•		City or To	wn, State)				
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2 a	calC	29a. Certifier Certifying Phy	rsician: To the best of niner: On the basis of ex	ny knowledge, de	ath occurred at the t	ime, date and p	place, and due to the	cause(s) and ma	nner as s	tated.		
in 24 in 24 ine Fi	edical	one)	and manner stated	d.								
With To	Σ	29b. Signature and title of certifier N	dono	HD		se number	AD AD	29d. Date signed	(Month,	Day, Year)		
					3000	1600.	74	6/10	10	5 ,		
5		30. Name and address of person who of 100 - HOSPITA C	ompleted cause of deat	h (Item 23a) (Typ	e, Print) /NCE	FRE	3P DERICU	HD	200	578.		
Sta Registr		31. Date filed (Month, Day, Year) JUN 1	32. Registr \$5	Signature	Sperte	,						

			For	State of Maryland	d / Depa	artment of H	ealth and M	lental Hy	giene	200	0.0	010
		•	State Registrar			rtificate of l		F	Reg. No.	JUb	20	616
	Physicia	an	1. Decedent's Name (First, Middle, La	-				2. Date of Dea Month	Day	Year	3. Time of	
	/Medic	al	YONG NAM KI 4a. Facility Name (If not institution, gi			4h City Town or	Location of Death	June	4c. Coun	2006 ty of Death	8:09	P "
jei	Examin	er	13019 Broadmore				Spring			tgome	:v	
-	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. ia	st birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da)	h	+	lace (State of	or Foreign
	Director		234.92.9498	1ŒM 2□F 61	Yrs.	Months Days	Hours Will.	Feb.13	, 1945	Kore		
	and .		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation	***			1	0d. Inside C	ity Limits
	Maryli f eho	tor	Maryland Montgom	ery Si	lvor (Spring					1 🔀 Yes	2 🗌 No
	r 28a	Directo	10e. Street and Number	ery 51	TAGE	10f. Zip Code			10g. Citizen o	f What Cour	itry?	
	th with		13019 Broadmore	Road		20904			U.S.			
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. R	ace - Americ lack, White,		
36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Spec	ity: Asia	n	
5-0036	within 72 hours after death with the Maryland ene. Then "neturel", or iteme 23a or 28a-f ehow the Maulcal Examiner and the motified at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/In	dustry	
215	hin 7: B. "n Madi	Completed	(Specify only highest gi			kind of work done of DO NOT use retired		1	Comput	ter Sc	ience	Corp.
2	filed wi Hygien sther th	Con		College (1-4or 5+) 5+ Years	Co	omputer P	rogrammer 18. Mother's Name					
and	I be fill haid Haid Haid Haid haid office of the haid office of the haid haid haid haid haid haid haid haid	Be	17. Father's Name (First, Middle, Las Seong Hwan Ki					Kim	Maiden Sum	ame)		
Maryland 2121	should be filed within 72 hours after death with the Marylan ad Mental Hygiens. marked other than "neturel", or Items 23a or 28a-f show marked other than "neturel", or Items 23a or 28a-f show marked other than "neturel".	၉	Seong Hwan K1: 19a, Informant's Name/Relationship		19b. Maili	ng Address (Street			ar, City or Tow	n, State, Zip	Code)	
Σ	nd 2 selith ar 27 to rr trau		Jeong Sim Kim/Wi	fe	13019	Broadmo	re Road,	Silver	Spring	, Mary	land	20904
ore,	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	20b. Pl	ace of Disponentery, cre	osition (Name of matory or other place	:e)	Date	20c. Location	n - City or To	wn, State	
Ĕ	Pag ment		4 Donation 5 Other (Spec			Mem. Park		/2006		Maryl	and.	
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked to any injury or other traumatic evides.		21. Signature of Funeral Service Lice	on see	H.	2. Name and Addre INES-RINA 1800 New	ss of Facility LDI FUNER Hampshire	AL HOME Ave, S	INC.	Spring	, MD	20904
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death y one cause on each line.	. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximation	tween
	Physician		Immediate-eause (Final disease or condition Hepstocellular Carcinoma (Liver Cancer) 3 years									
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	te be executed ysicien and te burial-transit		resulting in death) Last									
8760,	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	dical		d								
× 68	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnal	ncv				23d (Date of deliv	erv	-
Вох	etten etten 1 for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	'			Month	-	Year
P.O.	by the achec	hysi	9 Unknown	9 Unknown								
	9 P P	ρ	Part II. Other significant conditions	contributing to death but not resu	ılting in the u	underlying cause giv	en in Part I.		obacco use co Yes 2 □ No	co use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) Probably 4 \(\text{Deunknow} \)		
oro	v requir been si should	Completed										
Sec	has t	mpi							osy ormed?	prior to co death?	psy findings mpletion of o	cause of
la		မ င်	25. Was case referred to medical		 		26. Place of Deat		20At No	1 🗆 Yes	2 2 No	
S	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	00	ome 5 kd Resid		ther (Specia	y)	
0 0	ng Ph Iter th ineral		27. Manner of Death 1 SNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe I	how injury occ	urred		
slo	Attending in death.	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be one Blace of Injury At he	mo form of		Yes 2 □No	28f. Location (Street and Nu	mher or Rus	A Route Nun	nher
Division of Vital Records,	after after Direct in by	Certification;	4 ☐ Homicide determine	28e. Place of Injury - At ho building, etc. (Specify	()	neer, raciory, onice		City or To		77207 07 11070		1507,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director,	Medical C		Physician: To the best of my know aminer: On the basis of examinat and manner stated.								s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mo		29c. Licens			29d. Date sig			
	10		My un		0261 (7 -	100	57802		June	12,2	2006	
			Wells Messorsm	o completed cause of death (Item		Broadn	57802 Jay, Balti	more,	Margli	md	21231	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 13	32 Régistrar's Signa 2006	ture	all						

		For State Registrar	State	of Mary	•	artment of I rtificate of	Health and N <i>Death</i>		iene2006	20213			
- A		1. Decedent's Name (First, Middle	, Last)					2. Date of Deat	h Day Year	3. Time of Death			
Physicia		Charles Hen	rv Kito	hen.	Jr.			Time	(2) 200°C	5 4:00 P.M.			
/Medic Examin		4a. Facility Name (If not institution Washington		4c. County of Dea	on County								
						_	erstown If Under 24 Hrs.	0 Data -4 Bists					
Funeral Director		5. Social Security Number 219–20–2901	6. Sex 1 ★ M 2 ☐ F	7. Age (In	yrs. last birthday) 78 Yrs.	Months Days		8. Date of Birth (Month, Day, August	18" 1927 T	thplace (State or Foreign Juntry) /irginia			
		Usual Residence of Decedent				1							
ylan		10a. State 10b. County 10c. City, Town or Lo				_				10d. Inside City Limits			
Mar B-1 8	ctor	Maryland Wash	nington		Hage	erstown	·			1 ☐ Yes X☐ No			
ith the	Director	10e. Street and Number			10f. Zip Code		1:	0g. Citizen of What Co	ountry?				
23a	a	17908 Pin Oak					21740	U.S.A.					
r des	Funeral	11. Marital Status	Armed Forces?					ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi				
s afte	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 (A) Yes If Yes, G Year or	2∐No Sive Dates:	10-10-45	1 ☐ Yes 2 💢 No	Specify:		Specify: V	Mhite			
2 hours		15. Decedent	t's Education		16a. Dece	dent's Usual Occu	pation	.	16b. Kind of Business	/Industry			
nin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work ed)	ing					
d with	E O	11	College	(1 401 51)	Tran	nsmission	Assemble	r	Truck Mar	ufacture			
oth oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam						
should be tiled within 72 hours after death with the Maryland and Manyland Hygiene. In a Hygiene. In a Meulcal Examination be notified at umatic event, It a Meulcal Examination.	P P	Charles Henry		Sr.				····	Rogers Kit				
pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By Injury or other traumatic event, its Medical Examinar must be notified at applete.		19a. Informant's Name/Relations Mary Catherine		(wife)					City or Town, State, Maryland				
ss 1 e		20a. Method of Disposition 1X Burial 2 □ Cremation	2 Demount from		0b. Place of Dispo cemetery, cre	osition (Name of matory or other pla			20c. Location - City or				
Pages ment of ant: If it ury or o		4 Donation 5 Other (S		C		vn Mem Pa		6-06	Hagerstown	n Maryland			
permit. Departr Import any inj		21. Signature of Funeral Service	N. X				neral Home yland 21742						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
Physician		Immediate Cause (Final disease or condition	with	Onset and Death									
/Medical		resulting in death)	Due to	a. According to the prostate with one and Death of the prostate with the pros									
Examiner		Sequentially list conditions	b	li	idespr	ead W	it sesson.			10 years			
р ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a co	nsequence of):								
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
o rou, cate be execut physicien and the burial-tra	Ü	resulting in douting case	Due to	o (or as a co	nsequence of):								
icate be executed physicien and the buriat-transit	dical		d										
certific nding p	/Me	IF FEMALE:	23c. If yes, o	utcome of p	regnancy				23d. Date of de	livery			
that the death certifined by the attending I deteched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 🗀		☐Ectopic pregnand ☐ Other (specify)	су		Month	Day Year			
the dy the deched	ysk	1 ☐ Yes 2 ☐ M6 9 ☐ Unknown	9□ Unk										
	by Pt	Part II. Other significant condition	23e. Did tot	23e. Did tobacco use contribute to the cause of death?									
law requires as been sign								1 □ Y€	s 20⊒400 3 □ P	robably 4 Unknown			
N N D 0	Completed							24a. Was a	n 24b. Were a	utopsy findings available			
L	E				/			autops perform	ned? death?	completion of cause of			
VICIAN: The certificate rector, peg	0	25. Was case referred to manca	í				26. Place of Dea	h (Check only on					
9	To B	examiner?	Hospital:	Inpatient	2 ER/Outpatie	nt 3□ DOA O	ther: 4 Nursing H	ome 5 Reside	ence 6 Other (Spe	ecify)			
	<u>:</u>	27. Mannel of Death 1 Naturat 5 Pendir	/8.44	e of Injury onth, Day Ye	ar) 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe how injury occurred					
VISION (Attending I are death. rector; After by the funer	atie	2 Accident investi	gation			M 10]Yes 2 □No						
DIVISION I or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 288. Pla	ce of Injury - Iding, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,			
urs a		On Cartifica ATT ANTHUR	na Dhualeinn. To I	has been all on	si kecamban dan dari	the contract of their	tono data and stage	and thus to the as	ssae(s) and manner a	e etakut			
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai		Examiner: On the		mination and/or in				ate and place, and du				
within 2 To the	₹	29b. Signature and title of certifie	or	0	10/	29c. Licer	nse number	2	9d. Date signed (Mon	th, Day, Year)			
- s = 0		Mal Phone	1 PMD	Verse	not the	accom	1) 04	1359	JUNE 1	3,2006			
		30 Name and address of person	who completed ca	use of death	(Item 23a) (Type	. Print)	1)	4000	The state of	10 - 10			
1+11 40		LUBERT BRU	1hc 1	459	10100	IAC JVX	SEEL HI	AGERS.	10WM,C	11 21142			
Sta	ate	31. Date filed (Month, Day, Year,	1	Registrar's	Signature	1.4.				t			
Regist	rar	JUN 1	4 2006	Green	. 1. P	perel							

		1 - For State Registrar		State of M	arylan		artment tificate			ınd M		giene 2 (006	20	214
Dhysia	ian	Decedent's Name (First, M.									2. Date of De. Month	ath Day	Year '	3. Time	
Physic /Medi		George		onner		(nisley				1.5	do	21	ty of Death	111:4	15 A·M·
Exami	ner	4a. Fecility Name (If not insti	lution, give s	treet and number)	Car	naus	4b. City, To	wn, or	Location o	Death			eGA1	αd	
Funeral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. i	INPUS last birthday)	If Under 1		If Under	24 Hrs.	8. Date of Birt			place (State	or Foreign
Director		214-36-643	1 1 1 3	X4 2□F	64	Yrs.	Months	Days	Hours	Min.	Apr 1	7, 1942	Cour	'MD	
and w		Usual Residence of Deceder 10a. State 10b. Co			10c. City	y, Town or Lo	cation							10d. Inside (City Limits
Maryli -f eho	to	MD A	Allegar	ıy		LaVa	ale							1 □X (*e	s 2 No
h the	irec	10e. Street and Number					10f. Zip C	ode		_		10g. Citizen ol		ntry?	
ath wit	by Funeral Director	Box 3421							2150				JSA		
er dez	nue	11. Marital Status 1 ☐ Never Married 2 ☐	.	2. Was Decedent Armed Forces? 1 Yes 2	?	l l			ispanic Orig n, Mexican	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	- 14. Ra	ace - Ameri ack, White,		
D36	by F	3 Widowed 4 Divo		Il Yes, Give Year or Dates:	X.º		1 ☐ Yes 2[JNo.	Specify:			Spec	ity: wh	ite	
5-0 72 hou 72 hou	eted	15. Dec (Specify only I	edent's Educ ighest grade	cation completed)		16a. Deced	dent's Usual kind of work DO NOT use	Эссира доле а	ation during most	of workii	ng	16b. Kind of	Business/In	dustry	
Aghin Page	mple	Elementary/Secondary (0-		College (1-4or	5+)		nical O					Reichl	nold C	hemic	cal
nd 21215-0036 e filed within 72 hours after death with the Maryland at Hygiene. other then "natural", or iteme 23a or 28a-f show vent, the Madical Examiner must be notified at	Be Completed	17. Father's Name (First, Min	ddle, Last)			Onon	iloui o			r's Name	(First, Middle,	Maiden Suma		11011111	
land be Mental riked o	To Be	George F	ranklin	Knisley					Lu	la (V	Vhetzel) Knisle	у		
Mary ad 2 shot lith and h 27 to ma		19a. Inlormant's Name/Rela Charlotte Kr	tionship (Typ nisley	oe, <i>Print)</i> wife)	19b. Mailin	ng Address (Street a	and Numbe	r or Rura	LaVa	er, City or Town	n, State, Zij	D 215	502
Baltimore, permit. Pages 1 er Department of Hea Importent: If Item eny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from State	20b. P	Place of Disponential Place of Disponential	sition (Name natory or oth Morial F	ot Pr plac Park	е)	D	6/23/200	20c. Location 6 Cum	n - City or To berlan		MD
Baltimor permit Pages Department of I Importent: If Ite eny injury or of		21. Signature of Funeral Se	rvice License	Say	de	22					ome, PA e: Cumbe	erland, M	D 2150	2	
	`-	23a, Part1. Enter the diseas shock, or heart failure.	se, or compli	cations that cause le cause on each l	d the deatline.	h. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximately Interval Books and	etween
Physician		Immediate Cause (Final disease or condition resulting in death)	a	Met	istat	C	(0)	7		Con	nces	d		199	
/Medical Examiner		resulting in death)		Due to (or as	s a conseq	uence ol):									
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Ь	Due to (or as	s a conseq	uence ol):									
8760, rate be executed shysicien and the burial-transit	Examine	that initiated events	1.												
50, Se exe cien a		resulting in death) Last		Due to (or as	s a conseq	uence ol):									
8760, icate be ex physicien s the buria	dica							-							
Box 68760, death certificate be executed e attending physicien and d for use as the burial-transit	N/Me	IF FEMALE: 23b. Was decedent pregnat	nt 2	3c. If yes, outcome			7					23d. D	ate of deliv	ery	
o death he atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pred Other (spec					٨	Month	Day	Year
ecords, P.O. law requires that the de as been signed by the a should be deteched		9 Unknown Part II. Other significant co	nditions con		but not res	ulting in the u	nderlying ca	ISA CIVI	en in Part I		23e. Did t	obacco use co	ntribute të 1	the cause of	f death?
ds, uires ti signe id be o	d by	, art ii. Outor dig.iii.ozari									10	Yes 2□No	3 ☐ Pro	bably 4	Unknown
Vital Records, sicten: The law requires to certificate has been signe irector, page 2 should be to	Completed					_					24a. Was	an 24b	. Were auto	opsy linding	s available
I Rec The lav	L C										auto perfo	ormed?	death?	mpletion of 2∐ No	cause of
Vital Ficien: The certificate rector, pag	BeC	25. Was case referred to m examiner?	edical						26. Place	of Death	(Check only	7			
P	မ	1 ☐ Yes 2√ No	H	lospital:		ER/Outpatie			4 140			dence 6 🗆 O		fy)	
Jing After	ilon		ending ivestigation	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	M 28	injun Worl	yat k? Yes 2.∐		280. Describe	how injury occi	urrea .		
Division of Attending after death. Director: After	fical	3 ☐ Suicide 6 ☐ G	ould not be etermined	28e. Place of Ir	njury - At h	ome, farm, st						Street and Nun	nber or Run	al Route Nu	ımber,
Div	Certification:	4 Homicide		building, e	tc. (Specil	y)					City or To	wn, State)			
Divisit To the Hoepital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	edical ((Check only 2 Me		sician: To the bes	of examina										o(s)
thin 24 thin 24 the F	Med	one) 29b. Signature and title of c		and manner s					e number			29d. Date sign			
F ₹ 5 8)	Ma	Mun	2/		7	75	337			617	1106	,	
		30. Name and address of p	erson with co	empleted cause of	death (Iter	n 23a) (Type,	Print							0	0
H_		Qamar.	Zam	au 6	25 k	Keut	- Hve	<u>ν</u> ο	6	-0m	DEST	ind,	S	diso	7
S Regis	tate	31. Date filed (Month, Day,	Year) 2720	20	trar's Signa	BIUTE	Cools 1	-							

			_ FOI	partment of Health and I ertificate of Death		ene _{a.No.} 2006 20215						
ı	Physicia		1. Decedent's Name (First, Middle, Last) LOUISE KATHERINE KRIEMELMEYER		2. Date of Death Month May	Day Year 28 2006 7:20 A M						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Vantage House	4b. City, Town, or Location of Death		4c. County of Death Howard						
	Funeral Director		5. Social Security Number 579.20.2337 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 82 Yrs.	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) May 30,	(ear) 9. Birthplace (State or Foreign Country) Washington, DC						
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Howard Columb			10d. Inside City Limits 12∑Yes 2 ☐ No						
36	or 28a	Direc	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!", or Items 23e or 28e-f show among highly or other treumatic event, the Medical Example minist be notified at ADGS.	by Funeral Director	5400 Vantage Point Road 11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	21044 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White						
Baltimore, Maryland 21215-0036	within 72 ho lene. than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Years	ib. Kind of Business/Industry Oil Company								
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)									
Mary	12 sho h and h 7 is ma reuma			ailing Address (Street and Number or Ru								
more, 1	Pages 1 and ent of Health ht: If Item 2: ry or other i		Joseph O. Kriemelmeyer Jr./ 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 06/03/2006 Cedar Hill Cemetery 06/03/2006 Cedar Hill Cemetery 06/03/2006									
Baltii	permit. F Depertm Importar any Injui		21. Signature of Funeral Service Licensee		e Ave, Sil	Lver Spring, MD 20904						
8760,	death certificate be executed Washington and settlending physicien and for use as the buriar-transit	dical Examiner	st, Approximate Interval Between Onset and Death									
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year						
Δ.	8 6 8	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Munknown						
of Vital Records,	e law hes b je 2 si	Completed		ed? 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\sigma\) Yes 2 \(\sigma\) No								
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Othor	ath (Check only one							
	on offer	atlon: To	1 ☐ Yes 2 ☒ No	e of 28c. Injury at	ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
Division	2 g = =	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)						
	Hospital 24 hours e Funeral i	edical	29a. Certifier 1 ★ Certifying Physician: To the best of my knowledge, do (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, do (Check only one) 2 ★ Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)						
	To the Hos within 24 h. To the Fur completely	Me	29b. Signature and title of certifier	29c. License number D=55425	29	d. Date signed (Month, Day, Year) June 2, 2006						
,			30. Name and address of person who completed cause of death (Item 23a) (Ty Willie Mvemba, MD, 413 Commonwealt	ne Print)	B, Baltimo	ore, Maryland 21228						
Ľ.	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	geli								

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 State Registrar Amend #5 per FH G857 7/19/06 Hificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1.30 PM 2006 Diana Mae Kuszaj 04 06 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE AG-NES HOSPITAL 8. Date of Birth (Month, Day, Year) Oct. 5, 1946 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 59 Yrs. 5. Social Security 554 **Funeral** Days Hours 1 □ M 2 🔀 F 193-36-5334 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "netural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Anne Arundel Arnold MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21012 414 Beach Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel County other then Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School System 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth eny liqury or other traumatic event size. James Schmoke Thelma Posey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvester Kuszaj/Husband 414 Beach Road Arnold, MD 21012 20b. Place of Disposition (Name of cometery, crematory or other place)
Metro Crematory June 6, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Baltimore, MD 2006 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 1 nomas 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Cancer **Physician** /Medical Due to (or as a consequence of) Examiner From Breast Cancer Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Dunknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŏ 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 TYes 2 TNo within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number BAHRU, MD P17609 06/04/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGNES Hospital, 900 Caton Avenue Baltimore, MD 21228 egistrar's Signature 31. Date filed (Month, Day, Year)

JUN 0 9 2006 State Registrar

D. ANA

3

		-	1 - For State Registrar	State of Ma	ıryland				ealth a Death	and M		Rag. No	00	06.	20	217
)	Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Last CHARLES EDGAR 4a. Facility Name (If not institution, give	KNILL, J	R.		4b. City,	Town, or	Location of	of Death	2. Date of De Month JUNE	1 1 Da	20			of Death
	Funeral		FREDERICK MEMO 5. Social Security Number 6. Se		(In yrs. la	ast birthday)		DER]	If Under	24 Hrs. Min.	8. Date of Bin (Month, Da NOV 7	th	FRED		place (State	or Foreign
	Director Mot		Usuel Residence of Decedent 10a. State 10b. County			Yrs.					NOV 7	19	15	1	MD 0d. Inside	
	with the Mar 3a or 28a-f el	Funeral Director	MD MONTGO 10e. Street and Number 23310 PEACHTRE		CL	ARKSB	10f. Zip	Code 871				10g. Ci	izen of W	hat Cour		s 2 2 No
036	be filed within 72 hours after death with the Maryland stal Hygliene. do other then "natural; or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	<u>م</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S	1	Was Dece If Yes, spe	1.	spanic Orig n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	-		, White,		
21215-0036	d within 72 ho giene. ar then "natur i the Medical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	16a. Deced (Give life. FAR)	kind of wo DO NOT u	rk done d	<i>lurina</i> mosi	t of work	ing		ind of Bus		dustry	
Maryland	9 78 2 5	To Be (17. Father's Name (First, Middle, Last) CHARLES EDGAR 19a. Informant's Name/Relationship (T		R.	19h Mailir	og Address	Straat	ADD]	E K	EEFER				Code)	
	1 and 2 s Health ar em 27 is ther trau		MARY KNILL / S 20a. Method of Disposition	POUSE	20b. Pl		0 PE	ACHT	REE	RD.	, CLAF	RKSI	BURG	, MI		371
Baltimore,	permit. Pages Department of I Importent: If Its eny injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funery Savice Lidens)	MON	OCAC	Y CE	METE	ERY 6	у	/2006 HOME	BI	EALL	SVI	LLE,	MD
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused one cause on each lir	10.	n. Do not ent	P.O.	BOX de of dyin	86,	_BA	RNESV		E, M		Approxim Approxim Interval B Onset and MINU	ate etween d Death
	/Medical Examiner	5	resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as	CAI	RDIOM	YOPA	THY							YEARS	5
8760,	The law requires that the death certificate be executed ite has been signed by the attanding physicien and cage 2 should be detached for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):										
P.O. Box 6	that the death certific ed by the attending F detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s)						23d. Date Mon		ery Day	Year
	w requires that been signed by should be deta	۵	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying (cause give	en in Part I			obacco Yes 2	_	bute to t 3 ☐ Prot	he cause o	death?
al Records,		Completed									24a. Was auto perfo 1 Yes		di	nor to co	psy finding mpletion of 2 \(\text{No} \)	s available cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othi	200		Check only o		. 50			
Division of	Attending Physician: r death. ector: After this certification of the funeral director.	ition; To	1 Yes 2 A No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)	ry	ER/Outpatier 28b. Time o Injury		28c. Injun Worl	4 🗆 140		me 5 - Resi 28d. Describe				у)	
Divis	1 1 te o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, et	c. (Specify	v)					28f. Location (City or To	wn, Stati	9)			mber,
	Hospitai 24 hours a Funerei i etely filled	edicai	29a. Certifier 1 Certifying Phyone) 2 Medical Example 2	ysician: To the best niner: On the basis of and manner sta	examinal	wledge, deat tion and/or in	h occurred vestigation	at the time n, in my o	ne, date an pinion, dea	d place, th occuri	and due to the red at the time,	cause(s date an) and mar d place, a	ner as s nd due t	tated. o the cause	(s)
	To the within To the compli	Me	29b. Signature and title of certifier)		c. Licenso					-		Day, Year)	
)	Y		30. Name and address of person who d	completed cause of d	eath (Item	1 23a) (Type,		D44 /	· フ I			JUN	IE 1:	4, 4	2006 2087	6
	Sta Regist	ate	BARRY R. NAH 31. Date filed (Month, Day, Year)	32. Figistr	0528 ar's Signa	BOL	AND	FARM	RD.	, #	104, G	ERM	ANTO	, NWC	MD	

		State of Maryland / Dep		lental Hygie	ene2006	20218								
		- State Registrar 1. Decedent's Name (First, Middle, Last)	nincale of Death	Reg 2. Date of Death	. No.	3. Time of Death								
Physicia		William Robert Lockhart		June 11,	Day Year	7:55 A M								
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June II,	4c. County of Death									
Examine	er	Wilson Health Care Center	Gaithersburg		Montgomer									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Linder 1 Vear If Linder 24 Hrs	8. Date of Birth	0 8:45	place (State or Foreign htry)								
Director		096-16-5000 1⊠M 2□F 83 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Feb. 23,	1923 New	York								
land ow	Ì	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits								
Many Feh	ţo	Maryland Montgomery Gaithers	sburg			1 ☑XYes 2 ☐ No								
n the	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?								
23a c	a	301 Russell Avenue	20877	U	nited Stat	es								
r dea	neur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,									
urs efte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No WWII If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: W	nite								
72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation	ina 16	b, Kind of Business/In	dustry								
Man "	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	a kind of work done during most of work DO NOT use retired)		1	1 .								
iled v Hygie thar t		17. Father's Name (First, Middle, Last)	neer	لـا e (First, Middle, Ma	ucent Tech	nologies								
uld be f Mental P rked of tic ever	To Be	William Lockhart	Mary	17-1-1	idon damano)									
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, it a Mardical Exercitival for incitified at once.			ing Address (Street and Number or Rum Lorraine Avenue, M											
tam 2				Date 20	c. Location - City or To									
Page Introduced Introd		1 □ Burial 2 □ Cremation 3 □ Removal from State Metro	osition (Name of protection of political products) DPOLITAN June 120	$^{12}_{06}$, A	lexandria,	VA								
Definition Definition Department of mportant: If it in injury or o once.			2. Name and Address of Facility De			MD 20077								
40560		23a. lart. Brief the disease, or omplications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, and proximate interval Between												
		nock, ar half failure. List only one cause on each line.	ter the mode or cyling, such as cardiac o	or respiratory arrest	•	Interval Between Onset and Death								
Physician /Medical		disease or condition resulting in death)	ancer			Years								
Examiner		Due to (or as a consequence of):				1								
p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cheese of Figure 4 that initiated events c.												
ecute and -trans	Examiner	Cause (Discose of Irijury that initiated events resulting in death) Last C. Due to (or as a consequence of):												
e be ex	cai E	555 (5) (5) (5) (5) (5)												
ificate g phys	0.00	d												
h cert	M/	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 31	⊒Ectopic pregnancy		23d. Date of deliv	,								
The Lour requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		Other (specify)		Month	Day Year								
thet the by detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?								
w requires w reduires some significant specification is should be	ed b			1 ☐ Yes	2 □ No 3 □ Prob	pably 4 dunknown								
has be	ompieted			24a. Was an autopsy performe	prior to co	ppsy findings available impletion of cause of								
	O				No 1 ☐ Yes	2 No								
VICAL sician: 1 certifical rector, p	o Be	25. Was case referred to medical examiner? Hospital:	Othor	(Check only one)										
ding Physician: th.	-	1	of 28c. Injury at	me 5 Hesideno 28d. Describe how	e 6 Other (Specification)	ÿ)								
nding ath. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No											
or Atte free des pirecto in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, efc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,								
s ital		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the caus	se(s) and manner as s	tated.								
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only one) 2 ☐ Medicel Exeminer: On the basis of examination and/or is and manner stated. 29b. Signature and title of cert/film	vestigation, in my opinion, death occurr		and place, and due to									
12+1	-	· St Dohn	0.20148	J	une 11	2006								
		30. Manne and address of person who, completed cause of death (Item 23a) (Type Stoven 1) of the Stoven Russell Russell	Hve. Gathers	burg M.	d 208-	17								
Sta Registra	-	31. Date filed (Month, Day, Year) JUN 13 2006 32 Adgistrar's Signature	ale											

			1	For State Registrar	State	of Maryland / I	-	ent of F		Mental H	ygiene Reg. No.?	006	20219
		Physici	an	1. Decedent's Name (First, Midd						2. Date of D Month JUNE	Day	Year 006	3: Time of Death 8:55 P M
		/Medic Examin		Mary Louise L 4a. Facility Name (If not institution RAVENWOOD LUTH	on, give street and nu			City, Town, o	r Location of Dea		4c. Coi	unty of Death	
		Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. last bi		nder 1 Year ths Days	If Under 24 Hrs Hours Min	. (Month, L	Day, Year)		place (State or Foreign intry)
		Director		214-34-1104 Usual Residence of Decedent		69				Feb.	16 1937		yland
		e Marylar Be-f show	Director	10a. State 10b. Count Maryland Was	-	10c. City, Tow	rstown	1			T		10d. Inside City Limits 1√2 Yes 2 □ No
		with th	I Dire	10e. Street and Number	wa Ctwaat		10	f. Zip Code	1740			of What Cou	intry?
	36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be multified at	by Funeral	11 W. Baltimo 11. Marital Status 1 Never Married 2 Ma	12. Was Dec Armed F arried 1 _ Yes If Yes. G	2 ₹ No			1740 dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	10- 14.	ISA Race - Ameri Black, White, ecify:	, etc.
	21215-0036	in 72 hours n *natural* hedical Ex	Completed b	(Specify only high	ent's Education est grade completed,	16a	. Decedent's	Usual Occup	during most of wo	orking	16b. Kind o	of Business/fr	nite
	212	e filed within al Hygiene. other than vent, the Ma	Com	Elementary/Secondary (0-12)	0	1-4or 5+)	Spray	Painte		mo /First Midd			facturer
	land	ild be fil ental H ked oth ic even	To Be	17. Father's Name (First, Middle Earl Elmer Ne						me (First, Middle) e Cather			
	Maryland	2 should be and Mental I is marked or raumatic eve	-	19a. Informant's Name/Relation	nship (Type, Print)				and Number or R	lural Route Num	ber, City or To	wn, State, Zi	
		s 1 and 2 of Health s item 27 is	1	Dennis W. Lon 20a. Method of Disposition		20b. Place o			oad, Clea	ar Sprin Date		yland ion - City or T	
	Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 🏋 Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	State	stown	Cremat	ory 6/1				Maryland
	Ball	permit. Departr Imports any inj		21. Signature of Euneral Service	e Licensee	lenn C	X		ss of Facility Lson Blvd	Minnich d. Hage			
4		Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition			not enter the	mode of dyir	ng, such as cardia	c or respiratory	arrest.		Approximate Interval Between Onset and Death YCALS
		/Medical Examiner		resulting in death)	Due to Ch	or sa consequence	Trucki	ic pu	lmoray	dire	aic		YEARS
		be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	dylatensi	(OI):						YCARS
	68760,	cate be ex physician a the burial	edical Ex	Tosuling in doubly East	d	Not as a consequence	Mel	i tu					YEAR.
	P.O. Box 6	ne death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregnancy birth 2 □ Fetal death nant at time of death nown		oic pregnancy or (specify)	У		23d.	Date of deliv	rery Day Year
		juires that the signed by itd be detacted	by	Part II. Other significant condi	tions contributing to	death but not resulting	in the underly	ing cause giv	ven in Part I.		I tobacco use d] Yes 2 □ N		the cause of death?
ŀ	ry Louise Vital Records,		Completed							24a. Wa aut per 1 🗆 Yes	opsy forme	4b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
		Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2 ER/O	utpatient 3	DOA Oth	or /	ath (Check only		Other (Speci	fv)
	_	ding h. After fune	ıtlon; T	27. Mann of Death 1 Natural 5 Pend 2 Accident invest	28a. Date	of Injury 28b.	Time of Injury	28c. Injur Wor		7	how injury oc	, , ,	
そうと	Division	el or Attendi s after death. Il Director: A id in by the fu	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be mined 28e. Plac build	e of Injury - At home, f ding, etc. (Specify)	arm, street, f	ictory, office			(Street and Ni own, State)	umber or Run	al Route Number,
10-		To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical (al Examiner: On the	e best of my knowledg basis of examination a nner stated.							
2		To the within 2 To the complete	W	29b. Signature and title of cartin	fier			29c. Licens			29d. Date si	gned (Month,	Day, Year)
	C	2-8		30. Name and address of personal LAYCEN	BAL ARUM	ise of death (Item 23a) M) 346 Registrar's Signature	(Type, Print) - HILL	STACC	T, HAGI	ilstown	, אם	-2171	4D·
		Sta Regist		31. Date filed (Month, Pay, Yes	ľ 3 2006 ^{32.}	Registrar's Signature	Spe	W					

Amend Item #20b Per FH C857 7/06/06 JH and Mental Hygiene 20220 For State Amen ditem#25,27,28a-f,perME,g859,9/18/entificate of Death Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:33 P M June 13, 2006 Frank Vernon Lothry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. 232-44-7034 80 6/15/1925 Director West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or itema 23a or 28a-f shov The Medical Examinar must be nutified at 1 Yes 2 □ No Director WV Preston Terra Alta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Sanders St. 26764 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army 12 Soldier permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Α. Lothry Louise Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Lothry/ Brother 310 Sanders St., Terra Alta, West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory 6/ **14**/06 Morgantown, WV 21. Signature of Fundral Service Licensee 22. Name and Address of Facility 32 S. Second St. 23a. Part 1. Enter the diseas Stewart FUneral Home Lew Oakland, MD 21550 Part1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral Pneumonia 5 days /Medical Due to (or as a consequence of) Examiner Chronic Bronchitis 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine ig physicien and as the burial-transit Fracture of Left Hip 7 Days Due to (or as a consequence of): Box 68760, ICAL EXAMINER Physician/Medical for use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ Acute Renal Failure 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 X Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 100 No ဥ 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Hospitel or Attending Injury TENNATURAL 5 Pending death. 1 ☐ Yes 2 🕅 No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu unknown M investigation unknown 2 Accident subject fell 6 Could not be determined 3 Suicide 28f. Location (Street and Number of Bural Boule Number. City or Town, State) 308 Sanders Street Terra Alta, W.V. 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Home 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D42464 6/14/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sotiere Savopoulas, MD N. Fourth St., Oakland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUN 16** 2006 Registrar

古河市

			For State Registrar	State of I	Marylan		artment of H		d Mental Hy	giene ₂	006	20221
	Physici		Decedent's Name (First, Middle, L. Elayne C. Lucas	ast)					2. Date of De Month	Day	Year 2006	3. Time of Death 8:35 P
	/Medio Examir		4a. Facility Name (If not institution, girlichrist Hospic		er)		4b. City, Town, or Towson	Location of De	June 12	4c. Cou	unty of Death timore	
NA C	Funeral Director			Sex 7. 1 □ M 2√2 F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	frs. 8. Date of Bird (Month, Da 11/11/	y, Year)	9. Birth Cou Mary	place (State or Foreign ntry) 1and
55.8	the Maryland 28a-f show	tor	10a. State 10b. County MD Howard			, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2√2 No
90	Air air	Funeral Director	10e. Street and Number 3129 Brookmede F	≀d.			10f. Zip Code 21042			10g. Citizen USA	of What Cou	ntry?
9002 71 9	72 hours after death in natural; or iteme 23 death in terms.	þ	11. Marital Status 1 Never Married 2 Married \$ Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ☑No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		Race · Amen Black, White, ecify: Wh	
9		Completed	15. Decedent's 6 (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4	or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired ball Coac	furing most of)	working		of Business/In	versity
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セーフ	C, Mar 1 end 2 sh 1 eelth and		19a. Informant's Name/Relationship Eric Lucas/Son 20a. Method of Disposition	(Type, Print)	20b. P	1021	5 Shirley	Meado	Rural Route Number N Ct. El. Date	Licott	own, State, Zip City, on - City or To	MD 21042
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LucAS,	Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that cau	ised the death	4	112 Old C	olumbia	a Pk. Eli	Licott		
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a <i>E</i>	SOP as a comequ		eal c	once (2			Onset and Death
035		ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	·						
9	VISION OF VITAL MECONOS, P.O. BOX 06/00, Attending Physicien: The law requires thet the death certificate be executed redath. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Feta nt at time of d	I death 3	□Ectopic pregnancy □ Other (specify)			23d.	Date of delive	ery Day Year
1	w requires thei been signed to should be detented to the should be det	þ	Part II. Other significant conditions	contributing to deal	th but not res	ulting in the u	inderlying cause give	en in Part I.		obacco use d Yes 2 🗆 No		he cause of death?
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70	UNISION OF VITAL MECOLOS, P.O. BOX O I or Attending Physicien: The law requires that the death certific effer death. Director: After this certificate has been signed by the ettending p I in by the funeral director, page 2 should be deteched for use as	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati			ER/Outpatier 28b. Time o Injury	of 28c. Injun Worl	er: 4 🗆 Nursin	Death (Check only of g Home 5 Resident 28d. Describe I	dence 6 🗗		MHOSPIO
č		Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of building	, etc. (Specif	y) 	reet, factory, office		City or Tou	vn, State)		al Route Number,
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	To To Toon	2	29b. Signature and title of certifier M. H. H.	my Al	y , "	10	29c. Licenso	JZ05	S .		gned (Month,	*
(2)02		30. Name and address of person wh	BMC 6	701 N	Char	les St. B	alto. M	nd ZIZO	4		
	St Regist	ate rar	31. Date filed (<i>Month, Day, Year</i>) JUN 1 4	2006 32. Reg	Atrar's Signa	ture	Snail ,					

DHMH 17 Rev 1/2001

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Amend item 21 per fh 9856 6-26-06 yt
State of Maryland? Department of Health and Mental Hygiene

- State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 **Physician** MARY LUTTRELL June 6, :40 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Jniv. of Maryland Medical System Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Days Hours 94 Yrs. 236-28-5954 Director 10-11-1911 West Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r then "natural", or items 23a or 28e-f show the Medical Evant at most be notified at WV Jefferson Shepherdstown 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25443 80 Maddex Drive USA filed within 72 hours after death Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tape Library I.R.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other treumatic event 2008. Arthur Hayes Stuckey Vallie Mae Avey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul D. Luttrell/Son 53 Cline Drive, Inwood, WV 25428 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale Cemetery 6-9-06 Martinsburg, WV * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brown Funeral Home Charles M. Brown per dvr P.O. Box 821 327 W. King St. Martinsburg WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Clinical Aspiration /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Trauma

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 201-C2 Class II Odontoid Fracture Nasal racture, Clinical Aspiration 1 ☐ Yes X☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes X2 ☐ No 1 ☐ Yes X☐ No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Attending F 5 Pending investigation 1 Natural death. 1 ☐ Yes 2√ No Pt. Fell from bed 2X Accident of or Attend after death Director: 6/3/06 07:11 the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 80 Maddex Dr. Shepardstown Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Canterbury Center filled in by determined 4 | Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number A-Eslam MY P16545 June 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Afshin Eslami, Md 22 S. Greene St., Baltimore, Md 21201 31. Date filed (Mogth Day, Year) 2006 32 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day June 10, **Physician** 2006 Fay Lehrer 6:05P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bedford Court Assisted Living Silver Spring 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) JAN. 14, 1918 5. Social Security Number **Funeral** 063-05-8901 88 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No To Be Completed by Funeral Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3700 International Drive #247 United States of America 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No !! Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker oith and Mental Hygi 27 is marked other r treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Seymour Wieger Rose Seigel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #104, nt of Heelth a : If item 27 is or other tre 2212 Washington Ave. Silver Spring, MD 20910 Beverly Lehrer - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 06/12/06 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCREATIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence or) attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, AREITS MELLITUS 1 ☐ Yes 2 ☐ ¥6 3 Probably 4 Unknown ATHEROSELFRATIC CARDIOVAZULAR DILFAST 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medicai Certification; To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours efter within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) Da 124 45

State Registrar

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es have

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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		•	For State Registrar	State of	Marylar		artment rtificate			and Mer		iene g. No. 2	006	2.0	225
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V	/Medic Examin		4a. Facility Name (If not institution	on, give street and numb	per)		4b. City, To	wn, or l	ocation o		, une	1	nty of Death		
	LXamin		1014 Howard	Grove Court			Davi	ldso	nvil	le		An	ne Ar	undel	
	Funeral Director		5. Social Security Number 310–48–6331	6. Sex 7.	Age (In yrs. 58	last birthday) Yrs.	If Under 1 Months [Year Days	If Under 2 Hours	24 Hrs. 8. Min. Ju	Date of Birth (Month, Day, ine 8,	Year) 1947	9. Birth Cou Ohi	place (State on Intry)	r Foreign
	pu k		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	cation							10d. Inside C	ity Limits
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Maryland	d be f	o Be	Hubert Shader							ce Laı		Margori Sbir	arrio)		
<u> </u>	Shoul Mary mart	ပ	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailii	ng Address (5	Street a	nd Numbe	er or Rural R	loute Number,	City or To	vn, State, Zi	p Code)	-
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ē,	item othe		20a. Method of Disposition		1 ,	Place of Dispo	sition (Name	of er place) 1	Date	9 ;	20c. Locatio	n - City or T	own, State	
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Baltimore,	permit. Pages Department of h important: if ite any inlury or of		21. Signature of Euneral Service	e Licensee	50	22	Name and Hardes 12 Ric	Address Sty ige1	Fune: Fune:	ral Ho	ome, P. Annapo	A.	MD 21	401	
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	/Medical Examiner		resulting in death)	Due to (or	r as a consec					_,	000;	71.00		7.2.	,,,,
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P.0	that the		Part II. Other significant condi	tions contributing to dea	ith but not res	sulting in the u	nderlying cau	se givei	n in Part I.	==/	23e. Did tob	acco use c	ontribute to	the cause of o	Jeath?
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>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 🗆 Inj	patient 2□	ER/Outpatier	nt 3 DOA	Othe	4 □ Nu	rsing Home	5 Reside	nce 6 🗆 (Other (Speci	fy)	
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_	To the Hospital or Attending Ph within 24 hours elter deeth. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certify (Check enly orre) 2 Medica	ying Physician: To the bas al Examiner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred at vestigation, ir	the time	e, date and inion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s	;)
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		1	30. Name and address of person	on who completed cause	10		Print)		1001	1	4	OB /C	/ /	with G	
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		ate	31. Date filed (Month, Day, Yea		gistrar's Sign	ature	**			l					
	Regist	rar	JUN 0 9	2006	a St	A 200									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 20227 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 9, 2006 10:25 Bernhardt June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10515 Edgefield Drive Prince George's Adelphi If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**x** M 2 □ F Director 215-38-6925 65 March 28, 1941 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other then "netural", or items 23s or 28s-1 show environty or other treumatic event, the Madical Exercitar mast be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10515 Edgefield Drive 20783 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√Yes 2 No If Yes, Give Year or Dates:1961-63 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: SpecifWhite À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Test Technician Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Conrad B. Manq 2 Teresa C. Brahler 19a. informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Mang/ Wife 10515 Edgefield Drive, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 14, Gate of Heaven Cemetery 4 Donation 5 NOther (Specify) Entombment 2006 Silver Spring, Maryland Mausoleum 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Lung Cancer 9 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ፩ page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 12 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2√□ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home \$\frac{1}{2}\text{Residence} 6 Other (Specify) ٩ 1 🗌 Yes 2**√** No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17821 June 12, 2006 apple 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warren M. Ross, M.D. 4801 Dorsey Hall Drive, #201, Ellicott City, MD 21042 Registrar's Signature 31. Date filed (Month, Day, Year) State 13 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Indiana Mason 8:48 P Jun 7, 2006 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George's Clinton Nursing & Rehabilitation Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 3/□ F Yrs Director 214-42-5062 78 Dec 12, 1927 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Landover Director Prince George's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 2003 Palmer Park Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be tiled within 72 hours after onen of Health and Mental Hygiene.
ante if tiem 27 is marked other than "natural", or tiles usy or other traumatic event, tra Marical Estaminatory or other traumatic event, tra Marical Estaminatiny or other traumatic event, tra Marical Estaminating or other traumatic event, traumatical Estaminatical 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Elizabeth Eggins Hezekiah Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vanessa Mason/Daughter 7829 Burnside Road Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XI Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 06/14/06 ¹ 4 □ Donation 5 □ Other (Specify) **Brooks UM Church Cemetery** St. Leonard, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home sevell 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cons ence of Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (o as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the attending property detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performe 2 No 1 Yes 1 Tyes 2□ No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Naturai 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title q 2 60999 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paspula 20010 towers RUING Router 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

		•	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H			ene g. No. 20 (06 20229
	Physici		Decedent's Name (First, Middle, Las Joyce	t) L.	Causey	Mas	ssey	2. Date of Death Month June		Year 3. Time of Death 2000 M
	/Medio Examir		4a. Facility Name (If not institution, give			Owing			4c. County of	ert
	Funeral Director		5. Social Security Number 257–28–8675 Usual Residence of Decedent	9X 7. A	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 7	,1922	9. Birthplace (State or Foreign Country) Georgia
	ages 1 and 2 should be tiled within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-f show for other traumatic event, the Medical Examinar must be ricitized at	rector	10a. State 10b. County MD Calvert 10e. Street and Number		10c. City, Town or Lo			10	og. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ▼ No nat Country?
	er death with Items 23a o	Funeral Director	2208 Haleys Way 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{X} \text{Married} \)	12. Was Decedent Armed Forces 1 □ Yes 2X	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	0736 lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.
21215-0036	72 hours aft natural', or dical Exami	à	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra	If Yes, Give Year or Dates: ucation	16a. Dece	1 ☐ Yes Ž∭No dent's Usual Occup	during most of wor	king	Specify:	White iness/Industry
	lited within Hygiene. ther than " int, the Me	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or	5+) Homem	DO NOT use retired aker		ne (First, Middle, N	Own H	
Maryland	should be nd Mental marked o	To Be	Fred J. Liley 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	ng Address (Street	Mary L	ena Jones	3	
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once.		Eugene W. Causey 20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, cre	matory or other plac	(e)	Date 2	20c. Location - C	city or Town, State
Baltimore,	permit. Po Departme Important any Injury		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen			Cemetery Name and Addre Hardesty 905 Gale	ss of Facility Funeral	Home, P		MD 20765
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compositions, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ante	to the death. Do not en line. 2 1 1 0 5 0 1 6 s a consequence of): - 40 M	ter the mode of dyin	ng, such as cardiad	c or respiratory arre	st,	Approximate Interval Between
8760,	executed executed ial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as d	s a consequence of):					
P.O. Box 68	ath certif ettending for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	′		23d. Date Monti	,
	w requires that the de been signed by the c should be detached	ted by P	Party Other significant conditions of heum a ford	ontributing to death	but not resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did tob	4	oute to the cause of death? Probably 4 Unknown
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Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpat	ury 28b. Time o	of 28c. Injur Wor	er: 4 🗆 Nursing H	iome 5 Reside 28d. Describe ho	nce 6 ☐Other	* * * * * * * * * * * * * * * * * * * *
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	the Hospit nin 24 hour the Funera npletely fille	edical	(Check only 2 Medical Exen	ysician: To the bes niner: On the basis and manner s	t of my knowledge, deal of examination and/or in tated.	vestigation, in my o	pinion, death occu	irred at the time, da	te and place, an	nd due to the cause(s)
	To Your	Σ	29b. Signature and title of certifier	Di A	Deput death (Hom 22) The	29c. Licens	DGD S	54	6/5	(Month, Day, Year)
	St	ate	30. Name and address of person who all the state of the s	Jon	death (Item 23a) (Type, SES, M trar's Signature	0 69	5-4	meric	24	21035
	Regist		JUN 0 9 ZI	III	a B A	anthon .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Replacement State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 8, 2006 **Physician** 9:02a м Newman Doris Jean /Medical 4b. City, Town, or Location of Death Takoma Park 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 / 0 7 / 1 9 2 8 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗗 F 78 Indiana 308-28-8676 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiane. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow with jury or other traumatic event, the Medical Experient must be notified at once. 10a State 10h County 1 ☐ Yes 2 No Silver Spring Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 USA 609 Woodside Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 N Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert O'Connor Elizabeth Lally 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20910 and 609 Woodside Parkway Silver Spring, Md 19a. Informant's Name/Relationship (Type, Print) Charles Thomas Newman/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Md. Chesapeake Crem. 6/14/06 4 □ Donation # 5 □ Other (Specify) 21. Signature of Funeral Service Licen PHILIP AND FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S/P Mitral Valve Repair Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit S/P Myocardial Infarction Exam Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. F been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2□ No 1 TYes 1 Yes 2 X No Vital Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of carti 29c. License number 29d. Date signed (Month, Day, Year) 28883 July 17,2006 use of death (Item 23a) (Type, Print) 30. Name and address of perso who 7610 Carroll Avenue Takoma Park, Md 20912 Dr. Anvum Qazi 31. Date filed (Month, Day, Fear) 32. Megistrar's Signature State Coest

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2 0 2006

06-04140 Linda O'Neal

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Linda O'Neal 2 Date of Death Physician/ 1235 hrs June 15, 2006 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 7953 Sunshine Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days oreignew York Hours 089-52-9324 Director 47 11/29/1958 1 M 2X F Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 2 10a, State Glen Burnie Yes 2 X No MD Anne Arundel 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10f. Zip Code 10g. Citizen of What Country 5 23a or 28a-f Abe. Street and Numbe 7953 Sunshine Court #8 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black must be Armed Forces? White etc. 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: White f Yes. Give Yea Divorced Widowed ≦ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) marked other than " Mental Health Baltimore, MD 21215-0036 Clerical 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles P.O'Neil Pearl M.Chatterton Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is Pam O'Neil/Sister 16 Clarendon Aveune Providence, R.I.02906 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. Date 20a. Method of Disposition crematory or other place) 2 X Cremation 3 Removal from State t: If i Burial Important: injury or oth 6/19/06 Beltsville, Md. tment Chesapeake Crem. Donation 5 Specif 22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A ture of Funera Columbia Blvd.Silver Spring, Md20910 241 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and List only one cause on each line /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last put Physician/Medical X UNPENDED **AMENDED** attending physician or use as the burial item#23a, PII, 27, perME, G858,8/10/06 TT Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown signed by the atte 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ⋧ Diabetes, obstructive sleep apnea Yes 2 No 3 Probably 4 ✔ Unknown Completed ificate has been si r, page 2 should b of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: The certificate 26 Place of Death (Check only one) director, 25 Was case referred to medica Be examiner? DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Division 1 X Natural 1 Yes 2 Pending death Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. June 16, 2006 Name and address of person who completed ta se of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD egistrar's Signature 31. Date filed (Month Clay (191) -State Registra

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Committee Pauling Pa	Physician		Decedent's Name (First, Middle, Last)		Month	Day Ye	or w. di
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March Harricord Harricor			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U Months Days Ho	Under 24 Hrs. Durs Min.	8. Date of Birl	th 9.	Birthplace (State or Foreign Country)
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Meredith Ann Prather

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2006 20233

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 01 10 AM 6 13 2006 Flora Helen Purdy /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 21X F 2/11/1927 Director PA 173-20-5969 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County f show 10a. State the Medical Examiner must be notified at 1 XYes 2 No Director MDWorcester Ocean City or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 102 Yawl Dr. USA filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 0 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental H tant: If itam 27 Is marked off Be ဂ္ဂ Lee Wright Leila Bedillion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Shadyside Ct., Anna olis, MD 21403 David L. Purdy other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 4 Donation 5 Other (Specify) Sunset Memorial Park 6/18/2006 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signal to of Funeral Service Ligarnee 100284 108 William St., Berlin, MD 21811 indusin 23a. Parh. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) brezst **Physician** CIPICA 54005 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of) 68760, Physiclan/Medlcal Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? After this certificate funeral director, pag 1 Tes 2⊡No Vital 20 or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 22 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1444283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Decker 9733 He Herlmany Drive Beelin, MD 31. Date filed (Month, Day, Year) 32. Restrar's Signature State JUN 1 4 2006 Registrar

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I	Physicia	an	Decedent's Name (First, Middle, Last) TOURL WITH LAW DE	DDIIAM	Date of Death Month	Day Year	3. Time of Death
5%	/Medic	al	JOHN WILLIAM PU 4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Sune	4c. County of De	11100
	Examin	er	Washington County Hospital	Hagerstown		,	ington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign
	Director		228-38-3271 18 M 2□F 70 Yrs.	Months Days Hours Min.	June 6,		irginia
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	faryla •ho	5					1 ZWes 2 □ No
	the N	Directo	Maryland Washington 10e. Street and Number	Hagerstown 10f. Zip Code	100	g. Citizen of What C	ountry?
	3a or		319 Wahefield Road	21740		U.S.A	·
	me 2	Funeral		B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,
ထ္	or its		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	rican, etc.)	Black, Wh	ite, etc.
8	urai',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				White
2	filed within 72 hours after death with the Maryland Hygiene. Sthet than "natural", or iteme 23a or 28a-f ehow ent, the Masilsal Examinar must be notified at	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired)	ing 16	6b. Kind of Busines:	s/Industry
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au	Aental Aental rked o	To B	Gilbert Purdham	Doroth	ny Hamby-	- 2	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hygiene 1 Heelth and Mental Hygiene 1 Heelth and Mental Hygiene 1 Heelth and Mental Hygiene 1 Heelth and I the 23a or 28a-1 show item 27 is marked other than "natural", or item 8a Jean in a marked and other traumatic event. The Madical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rura	I Route Number, (City or Town, State,	Zip Code)
	of Heelth of Heelth item 27 i			Wahefield Road Hage			
Baltimore,	Pages 1 nent of H ant: if ite ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place) June		Oc. Location - City o	r Town, State
Ë	t. Partmen			rg Crematory 200			, Maryland
Ba	permit. Pages Department of Important: if it any injury or o		1 -m	22. Name and Address of Facility			eral Home
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	Diam'r in in a		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1/		-,	Interval Between Onset and Death
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Box	that the death ned by the atter s detached for u	clar	in the past 12 months? 1 Ves 2 All 0	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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O	Attending Physician: or death. ector: After this certifice by the funeral director, t	tlor	↑ □ Vatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation			,,	
Division of	or Attenuater deat Director: In by the	He	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office		et and Number or F	ural Route Number,
Ö	tal or A	Certification:	4 ☐ Homicide Storming building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Mon	th, Dey, Year)
			1 Jogsom Vents.	mu	4	2/20/	06
	8		30. Name and address of person who completed cause of death (Item 23a) (Type 5 Tep Len M. Socials 348 Miles	a. Print) St Hageast	our,	MD 21	740
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 2 7 2006 32. Signature	berte			

Yordham, John

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month June 2006 Pearl Yohn Pickett 12:15a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FutureCare Chesapeake Anne Arundel Arnold If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🗙 F 81 Yrs. 219-14-7750 Director June 18. MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at MD 1 TYPS 2 TYNO Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1171 River Bay Road 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hartford other then Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper National Bank 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Merle Yohn Helen Fryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl M. Pickett/Husband 1171 River Bay Road, Annapolis, MD June 7, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) Baltimore, MD 2006 21. Signature of Fynery Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician execut /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 1 Inpatient 2 ER/Outpatient 3∏ DOA this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 atural 5 Pending 1 TYes 2 □No death. investigation Accident after death Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comrans Hwy Millorsville, N lenniter KIEdIK 31. Date filed (Month, Day, Year) JUN 0 9 2006 Registrar

06-04312 Nathan P. Ryder

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Cei	rtificate o	t Dea	itn			Re	g. No.	_	JU	0 2020
Physicia ledical Examir	n/	Decedent's Name (First, Middle)		RICK RY	DER				1	Date of Deat Month une 20, 2	Day 006	Year		3. Time of Death 1012 hrs
1		4a Facility Name (if not institution Atlantic General Hosp		umber)		4b. City Berl	, Town, or Le lin	ocation of I	Death			rcester		
Funeral Director		5. Social Security Number 217-06-1730	6. Sex	7. Age (In yrs. I.	ast birthday) Yr	Mon	nder 1 Year oths Days	If Under 2 Hours	Min	Date of Birt		F	oreign	place (State or ntry) PA.
	ŀ	Usual Residence of Decedent	IMI Z F	22	- 11	3.				UAN.24	, 100	J-1		,
any	ŀ	10a, State 10b, County		10c. City,	Town or Loca	tion	-						1	10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ъ	MD FRED	ERICK	E	EMMITSB	URG								1 Yes 2 X No
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f short ranumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number				10f. Z	21727			10	g. Citizen		Countr	y?
with the		17209 MT. V.	IEW RD.	cedent Ever in U	S 13. W	as Dece		anic Origin	i? (Specif	fy Yes or No-		S.A. Race-A	merica	an Indian, 8lack,
Jeath v	Funeral	1 Never Married 2 M	Armed F	forces?	If '	Yes, spe	cify Cuban, I	Mexican, P	Puerto Rica	an, etc.)		White, e		
after o	by F		orced If Yes, Give Ye or Dates:	ar	1		2 X No					,-	VHI:	
36 hin 72 hours afte e. than "natural", dical Examiner		15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)	16a Decede during r		al Occupatio vorking life. [16b. Kind	of Busin	ess/Ind	dustry
36 thin 72 te. than '	ompleted	12	College (1-4 01 31)		MASC	N TEN	DER			(CONSI	ru(CTION
5-0C led wit Hygien other	O	17. Father's Name (First, Middle	, Last)		-		18	Mother's	Name (Fir	rst, Middle, N	laiden Sui	rname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	DENNIS		R	40h Maile	a Adda			RRY		RNDOI		21.1.	7-0-10
Baltimore, MD 21215-0036 pernit Pages I and 3 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatit event, the Medical	유	19a. Informant's Name/Relations			- 6					I Route Num SBURG ,				zip Code)
e, M and 2 Health item 2		TERRY M. RYDE:			Place of Dispo	sition (N	ame of ceme			ate				own, State
nor ages l ant of l nt: If		1 Burial 2 X Cremation 4 Donation 5 Other S		TOTA State	crematory or o	-		RTUM	6/22	2/2006	SMI	THSB	URG	, MD.
Baltimore, permit Pages ar Department of Hee Important: If ite	1	21. Signature of Funeral Service	Licensee ()	1			nd Address o			LES FU		L HOM	1E	
		John m	1. Ablil	les							-		2172	27-0427
Physician Medical		23a. Part J. Enter the disease, or failure. List only one cause	on each line.			tne mod	e of dying, s	ucn as car	diac or res	spiratory arre	est, snock,	or neart		Approximate Interval Between Onset and Death
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P.O. B res that the d signed by the	by P	Part II. Other significant condi	tions contributing	to death but not r	resulting in the	underly	ing cause giv	en in Part	1.					ne cause of death?
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tal Records ian: The law requi certificate has been	Completed									autop			r to co	mpletion of cause of
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/ital Frician:	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3		thor:	Nursing H		Residence	e 6 🔲 (Other:	
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Division of Vital Records, sopiual or Attending Physician: The law requir hours after death meral Director: After this certificate has been some all process. After this certificate has been so filled in by the funeral director, page 2 should it.	Certification:	3 Suicide 6 X Cou	ald not be	ice of Injury - At h			ory, office bu	ilding, etc.		or Town, S	tate) &_T	Number o	or Rura Str	al Route Number, City eet
lospita I hours uneral		4 Homicide 29a. Certifier 1 Continues	Physician: To the be				the time dat	e and nlac			, ,			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director. page 2 should be detached for use as the buil	Medical	(Check only one) 2 Medical Ex	aminer on the basis	of examination	and/or investig	ation, in	my opinion,	death occu	urred at the	e time, date	and place	, and due	to the	cause(s)
F 3 F 8	Me	29b. Signature and title of certif		21			29c. License							h, Day, Year)
		/	11)			O.C.N	1,E.			June 2	21, 200	6	
		30. Name and address of perso Mary G. Ripple MD.				11 Per	n Street,	Baltimo	re, MD	21201				
	tate	31. Date filed (Month) Page Year	7 2006 ^{32. F}	Rep strar's Signat	ture	1-	2.							
Regis	trar	2011 2	* 2000	wille	11 /	15 83	<u></u>							

Kenneth David Resh 1- For State

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death 2006 20238

		Registrar 1. Decedent's Name (First, Middle,Last)	Ochmodic	Of Death			leg No	- C	
Physici Medical Exam		Kenneth David Resh				Date of Dea Month June 13,	Day 2006	Year	3. Time of Death 2146 hrs
		4a. Facility Name (if not institution, give street and number) Route 219 at Rabbit Hollow Road		Accident	r Location of Death		Gar	ounty of Death	1
Funeral Director		215–36–7827 ₁ X _{M 2} F	n yrs. last birthday 76) If Under 1 Yea Months Day Yrs.		8. Date of Bi	,		thplace (State or gn untr MD
any		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	ocation	"				10d. Inside City Limits
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Maryl r 28a-f ed at o	Director	10e. Street and Number		10f. Zip Code			l0g. Citizen	of What Cour	ntry?
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eath wi	uneral	11. Marital Status 1 Never Married 2 Married 3 Married 2 Married 3 Married		If Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto R	city Yes or No ican, etc.))- 14.	Race - Ameri White, etc.	ican Indian, Black,
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15-0 filed al Hyg ed oth	Be C	17. Father's Name (First, Middle, Last) Arthur Resh			18.Mother's Name (F			,	
and 2 should be fi and 2 should be fi fealth and Mental I tem 27 is marked traumatic event,	9 B	19a Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Stree	et and Number or Rui		e Yos	_	. Zip Code)
MD 21 d 2 should th and Me n 27 is ma	-	Rebecca Grace Resh, Wife	l l		ermany Rd				
re, rad land land Healt fitem		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		position (Name of ce	metery,	Date	20c. Loca	ation - City or	Town, State
imore Pages 1 ment of H tant: If i		4 Donation 5 Other Specify:			, June 17,	2006	Gra	ntsvil	le, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 obsparment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other reaumatic event, the Medical		21. Signature of Funeral Service Licensee		2. Name and Addres	ıv⇔wı	nan Fu	neral	Homes	, P.A.
Physician		23a Part I. Elyter the disease or complications that caused the							11e, MD 215J
/Medical		failura List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cau	rdiovascular [Disease					Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a conseque							
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	ence of):						
	Examiner	cause. Enter Underlying Cause (Ulsease or injury that initiated							
secuted 1 and - transit		events resulting in death) Last Due to (or as a conseque d	ence of):						
(68760, certificate be executed and ing physician and use as the burial - transit	ian/Medical	UNPENDED AMENDED							1
760 icate b	/We	IF FEMALE: 23b Was decedent pregnant in the	of pregnancy					ate of delivery	
c 68 certif ending use as	cian	past 12 months?	e of death 5	Fetal death 3 Other (Specify)	Ectopic pregnanc	у	Moi	nth D	Pay Year
Box e death c the atten ed for us	Physic	1 Yes 2 No 9 Unknown g Unknown							
ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificater. The this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as t	by P	Part II. Other significant conditions contributing to death but	it not resulting in th	ne underlying cause (given in Part I.	23e. Did to	_		the cause of death? ably 4 Unknown
ords, I w requires is been sig should be	ted					24a. Was			topsy findings available
COFC Law re has be	Completed					autop			ompletion of cause of
tal Rec ian: The l certificate l		25. Was case referred to medical		26 Diggs	e of Death (Check onl	1 Yes	2 No	1 🗸 Ye	s 2 No
Vital hysician:	Be C	examiner? 1 Ves 2 No Hospital: 1 Inpatient	2 ER/Outpati		Other Nursing I		Residence	6 ✓ Other.	Scene
ing Phy After th	년 일	27. Manner of Death 28a. Date of Injury	28b Time	learned .		Bd. Describe			
ion trendii leath. tor: A	aţi	1 Natural 5 Pending 2 Accident Investigation		1	Yes 2 No				
Division of Vital Records, tal or Attending Physician: The law requir as after cleath. al Director: After this certificate has been seled in by the funeral director, page 2 should I	Certification:	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, s	treet, factory, office b	ouilding, etc. 28	Sf. Location (S		lumber or Rur	ral Route Number, City
Divospital of hours at hours at Inneral D	ပြီ	4 Homicide determined (Specify) 29a Certifier - Certifier Blue Table 1							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examina							
To To	Me	and manner stated. 29b. Signature and title of certifier		29c. Licens	se number		29d Date	signed (Mor.	oth, Day, Year)
		Curel		O.C.	M.E.		June 1	4, 2006	
		30. Name and address of person who completed cause of death	,		119				
		Ana Rubio MD. Assistant Medical Examine	Signatura	Street, Baltimo	ore, MD 21201				
S Regis	tate trar	31. Date filed (Month, Day, Year) 2006 32. Registrar's S	ngriature	Incorrect to					

i.	•	•	For State Ragistrar	State of M	aryland		artmeni rtificate			and M	-	giene 2	006	202	239	
3	Physici		1. Decedent's Name (First, Middle,	ŕ							2. Date of De. Month June	Day 6	2006	3. Time of Do	eath	
	/Medic	al	Elizabeth A. 4a. Facility Name (If not institution,	Rentner	}		4b City	Town or	Location o	f Death	- Curic		nty of Death			
	Examin	er	Anne Arundel Me					apol:				Anne Arundel				
	Funeral			. Sex 7. Ag	ge (In yrs. la	st birthday)	If Under Months	-	tf Under	24 Hrs. Min.	8. Date of Birt	Date of Birth (Month, Day, Year) 1/14/1916 9. Birthplace Country) New Je			Foreign	
ш	Director		153-09-5375	1 □ M 2 X F	89	Yrs.	North	Days	1.00/0		11/14/	916	New	Ĵersey		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation						10	d. Inside City	Limits	
	Maryl -f sho	tor	NJ Mercer		Law	rence	ville							1 Tes 2	. □ No	
	h the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Coun	try?		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, fra Mucical Examiner must be nuithed a	Funeral Director	61 Myrtle Ave.					8698					JSA			
	er dea	unei	11. Marital Status	12. Was Decedent Armed Forces	?	3. 13.	Was Deced If Yes, spec	lent of His ify Cubar	spanic Orio n, Mexican	gin? (Spe , Puerto l	crfy Yes or No Rican, etc.)	- 14. P	lace - America Ilack, White, e			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ XWidowed 4 ☐ Divorced	d 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	No		1 🗆 Yes	No DX	Specify:			Spe	cify: Whit	e		
21215-0036	2 hou		15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	tion			16b. Kind of	Business/Ind	ustry		
215	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us	e retired)	uring mosi	OF WORKI	ng	•				
21	ygien ygien rt, fre	S	8			Home	maker		10 Matha	de Nome	(Ciana Adiabata		Home			
and	ould be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Michael Ewiak Josephine Mi										ame)			
Maryland	should id Men marke matic	۴	Michael Ewiak Josephine Milecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City										vn, State, Zip	Code)		
	nd 2 s lith ar 27 is r trau		Susan Skinner (apolis					
Je,	of Hear item		20a. Method of Disposition		20b. Pla	ace of Dispo metery, cre	osition (Nam	ne of ther place)	D	ate	20c. Locatio	n - City or To	wn, State		
<u>ii</u>	Page		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	y Cro			1 _	6/10	/2006	Hamilt	on, NJ	Γ		
10a. State 10b. County 10c. City, Town or Location 10d. Ci										MD 21	1401					
760,	Physician // / / / / / / / / / / / / / / / / /	Ilcal Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a conseque	nce of):	Ju	fav	71	on	evo s is			Approximate Interval Betwee Onset and De ILM M. C.	ath A	
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the ettending physicien and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pr					23d. Date of delivery Month Day Year			ar			
	s that ned b e deta		Part II. Other significant condition	s contributing to death I	but not resul	ting in the u	inderlying ca	ause give	n in Part I.		23e. Did t	obacco use co	ontribute to th	e cause of dea	ith?	
ıd	w require been sig should b	ted	Cere provo	scular o	1150	RIL					10	res 2 □No	3 ☐ Proba	ably 4 Duni	known	
Vital Records,		Completed by	Cerebral	in tained	lons								b. Were autor prior to con death? 1 \(\text{Yes}	osy findings ava nptetion of cau 2 No	arlable se of	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Othe			(Check only o					
ō	Phys r this ral dii	.: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj (Month, Da		R/Outpatie 28b. Time o		8c. Injury Work	4 🗀 140		ne 5 Resident)		
Division of	Attending Ph r death. ector: After th by the funeral	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	м		? ′es 2 🔲 I	No						
Vis	Attendi er death. ector: A by the fu	HICE	3 Suicide 6 Could no 4 Homicide determin	289. Place of in	njury - At hor	me, farm, st	reet, factory	, office		2	28f. Location (S City or Tox		mber or Rura	Route Numbe	37,	
ō	rs after or set Direction	Certification:		, bonding, o	ne. (opdany)											
	To the Hospitel or Attent within 24 hours after deal To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminar: On the basis of and manner s	of examinati	vledge, deat ion and/or in	h occurred ivestigation	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)		
	To the vithin 2 To the comple	Σ	29b. Signature and title of certifier	- 1			290	License		_		29d. Date sig	ned (Month, L	Day, Year)		
			I wash	nen			L	/	965			01	1/00			
	or tage		Joseph Fr	no completed cause of	death (Item	De fo	Print)	H	ry	X	mnax	olis.	m	2140	1	
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signati	ure	arth o				-0	,				

			1 - For State Registrar	State	of Marylar		artment o			d Me	-	giene Reg. No.2	006	2021.0	
			Decedent's Name (First, Middle	, Last)			· · · · · · · · · · · · · · · · · · ·	0, 0,		2	2. Date of De	of Death 3. Time of Dea			
н	Physici /Medio		MARGARET JEAN	SMITH							Month June	07	2006	10:40 A ^M	
j	Examin		4a. Facility Name (If not institution	give street and nu	ım <i>ber)</i>		4b. City, To	wn, or Lo	cation of D	eath		4c. Co	unty of Death		
			15921 Attlebo	ro Road					Sprin				ntgome	ry	
	Funeral Director		5. Social Security Number 218.56.3871	6. Sex 1 ☐ M 2X F	7. Age (In yrs. 74	. last birthday) Yrs.	If Under 1 \ Months D		f Under 24 Hours N	Vin.	B. Date of Bir (Month, Da Jan. 4	th y, Year) • 1932	Cou	place (State or Foreign ntry) oma Park, MD	
	pue *		Usual Residence of Decedent 10a, State 10b, County		10c, C	ity, Town or Lo	ocation							10d. Inside City Limits	
	Aaryli aho	ō												1⊠Yes 2 □ No	
	28a-	Director	Maryland Montg	omery	51	llver S	10f. Zip Co	ode				10a. Citizer	of What Cou	ntry?	
	3a or		15921 Attlebox	- 0			209					U.S		,	
	deeth	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.	Was Deceden	t of Hispa	anic Origin	? (Spec	fy Yes or No		Race - Amen		
21215-0036	d within 72 hours after deeth with the Maryland jiene. r then "neturel", or Items 23a or 28a-f ahow the Madical Examiner count be notified at	þ	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced		2⊠No ive		If Yes, specify 1 ☐ Yes 2 🔀		Specify:	ueno Hi	can, etc.)	Sp	Black, White, ecify: Wh:		
2-0	72 ho	Completed	15. Decedent (Specify only highes)	16a. Dece	dent's Usual C	ccupatio	on ina most of	working		16b. Kind	of Business/Ir	ndustry	
2	within ene. then	nple	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use i	etired)	ing most of	WORKING	′				
121	filed w Hygier ther th	ပ်	10th			1	Iomemak						nestic		
Maryland	φ π ο Σ	Be	17. Father's Name (First, Middle, I George Samue		y, Sr.			18	Mild:		First, Middle,			dom	
2	d Men marke maric	၉	19a. Informant's Name/Relationsh		,, 51.	10h Maitir	ng Address (S	traat and					Magru		
Ma	d 2 sho th and th sm ?7 is m traum		Janet D. Picor		er							-		yland 20905	
	es 1 and 2 should b of Health and Menti fitam 27 is marked r other traumatice		20a. Method of Disposition	, 5446		Place of Dispo				Dat	-		ion - City or T		
<u>o</u> E	ant of Services		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			. John			067	/10/	2006	Silve	r Spri	no MD	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service I		+.	1 P	Name and A	ddress c	of Facility	JERA	I. НОМЕ	TNC		_	
	20200		23a. Part1. Enter the disease, or	complications that	caused the dea								Spring	Approximate	
	Physician		shock or fleart failure. List of the limmediate Cause (Final disease or condition resulting in death)	only one cause on	each line. astatic						ospiratory E	1031,		Interval Between Onset and Death Months	
	/Medical Examiner		Due to (or as a consequence of):												
		70	Sequentially list conditions,	b. — Due to	(or as a consec	quence of).									
	uted Insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,	,									
Ć.	exection and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):									
8760,	cate be executed physicien and the burial-transit	dical		d											
9		Med	IE EEN E												
Вох	deeth certifi e ettending id for use as	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		itcome of pregn		Ectopic pregr	nancy				23d.	Date of delive	,	
.O.	0 0 0	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Preg	nant at time of one	death 5	Other (special	(y)					Month	Day Year	
<u>α</u>	that the sed by th detache		Part II. Other significant conditio	ns contributing to d	leath but not res	sulting in the u	nderlying caus	e awen i	n Part I		23e Did to	phaceo use	contribute to t	he cause of death?	
Records,	Se Go	d by	•	.			ing sauc	o givori						pably 4 Unknown	
S	>	Completed									24a. Was	an 2	4b Were auto	opsy findings available	
	o - 6	mo				.,				-	autop perfo	rmed?	prior to co death?	mpletion of cause of	
tal	an: Th rificate tor, pag	0	25. Was case referred to medical					26	S Place of	Death (4	1 ☐ Yes Check only o	2 No	1 🗆 Yes	2 No	
of Vital	ysici is cel	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA	Othor					Other (Specif	(v)	
			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c.	Injury at Work?			d. Describe h			,,	
Sio	Attanding ir death. actor: After by the fune	catio	2 Accident investig	ation			М		2 □ No						
Division	al or Attand s after death il Diractor: , id in by the f	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place	e of Injury - At h ling, etc. (Speci	iome, farm, str fy)	eet, factory, of	fice		28	f. Location (S City or Tow	Street and Ni m, State)	umber or Rura	ul Route Number,	
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying (Check only ane)	Physician: To the examiner: On the band man	e best of my kno pasis of examina	owledge, death ation and/or in	occurred at the vestigation, in	he time, my opini	date and pl on, death o	ace, and	d due to the o	ause(s) and date and pla	d manner as s ce, and due to	tated. o the cause(s)	
	To tha I within 2 To tha I complet	Me	29b. Signature and title of certifier	00	111	7	29c. Li	cense nu	ımber			29d. Date si	gned (Month,	Day, Year)	
			1 /hou	L4Unn	MINE	_	D-	1645	58			June !	9, 2006	6	
	10		30. Name and address of person v	vho completed cau	se of death (Iter	m 23a) (Type,	Print)								
			Thomas E. Doll					, Su	iite #	304	, 01ne	y, Ma	ryland	20832	
* (Sta Registr		31. Date filed (Month, Day, Year) JUN 13	2006	Registrar's Signa	ature /	we								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 10,2006 8:52P M ELLEN STEINBACH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOI EASTON MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 M 2 T√F Yrs. 578 40 6854 **Director** MARCH 02,1911 WASHINGTON D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f show 1 ☐ Yes 2 No MARYLAND TALBOT EASTON Direct 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 29714 STANDISH STREET 21601 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 **HOMEMAKER** HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other treumatic event 9082: Be ဥ JOHN HENRY WILLIAMS BERTHA AUGUSTA JARBOE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH A. McCOY (DAUGHTER) 29714 STANDISH STREET EASTON, MD. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 06-14-06 SUITLAND, MD. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Funeral 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 ER/Outpatient 1 Inpatient 1 ☐ Yes 2 ₹ No 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Diractor: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D 36091 value no JUNE 12,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BESTGATE RD ANNAPOLIS BOAKYE 888 31. Date filed (Month, Pay Registrar's Signature State 2006 Registrar

		For State Registrar	State of Maryland	/ Depa		of He	ealth a				3	20242	
Physici	an	1. Decedent's Name (First, Middle, Last)				0, 0	-		2. Date of Dea Month		Year	3. Time of Death	
/Medi	al	Betty Lou Smith 4a. Facility Name (If not institution, give stre	et and number)		4b. City, To	own, or I	ocation of	Death	gusie	4c. 6	2006 County of Dear	8:40 M	
Examir	ier	Washington County H	ŕ		12. O.ly		agers				,	on County	
Funeral Director		216-38-0093	2 ▼ F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months		If Under 2 Hours	4 Hrs. Min.	B. Date of Birth (Month, Day Dec 29	1	9. Bin	thplace (State or Foreign ountry) aryland	
yland		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits	
e Mar	Director	Maryland Washingt	con	Hage	erstow	m						1 X Yes 2 □ No	
with the	Dire	10e. Street and Number 12 South Walnut St	-		10f. Zip C		740			10g. Citize	en of What Co	•	
death me 23	Funerai		Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decede			in? (Spec	ify Yes or No-	erican Indian,			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other treumetic event, Ite Madical Examinar ment by mulliand at once.	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					Black, White, etc. Specify: White			
21215-0036 d within 72 hours aff giene. or then "natural; or	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		(Give	lent's Usual kind of work DO NOT use	done du	ion ring most	of working	g	16b. Kind	d of Business	/Industry	
21; led wit lygiene her the	Com	10			Deli				(Prima Ministra		cery S	Store	
Maryland nd 2 should be file lth and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Daniel Edward Sou	ders						(First, Middle, ne Irei		,	niders	
lary	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street ar			Route Numbe				
Te, N 1 and 1 and Health em 27 other fr		Shirley M. Hartle 20a. Method of Disposition	20b. Pla	928 S ce of Dispos	t. Cl	air e of	St. A	Apt.	5 Hager	rstow 20c. Loca	n Mary	land 21742 Town, State	
Pages ent of nt: if it ry or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	notory, crem	natory or oth In Mem	iei piace,	1					Maryland	
Baltimore, permit. Pages 1 a Department of Hes Important: if item any Injury or othe	1	21. Surrature of Funeral Service Licensee	17:	22	. Name and	Address	of Facility	Doug	las A.	Fier	y Fune	ral Home	
10140	H	23a. Part1. Enter the disease, or complicat	ions that caused the death.								m Mary	rland 21742 Approximate	
Physician	Ś	shock, or head failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Intesten	inal	Per	for	stin	1				Interval Between Onset and Death	
/Medical Examiner			Due to (or as a conseque									2×	
pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque										
58760, icate be executed physicien and s the burial-transit	Examiner	that initiated events c.	Due to (or as a conseque	ence of):									
8760, ate be ex hysicien the buria	cal	d.											
Box 68 death certifica e attending ph ed for use as th	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy								23	23d. Date of delivery		
	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 5 Other (specify) 9 Unknown									Month	Day Year	
I Records, P.O. The law requires that the ste has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions contri	outing to death but not result	ing in the ur	nderlying cau	use giver	in Part I.			bacco use		the cause of death?	
ecord law requii as been s 2 should	Completed								24a. Was a			itopsy findings available completion of cause of	
Vital Rec itcien: The law certificate has I rector, page 2 s	1 - 1								perfor	med?	death?	2 No	
of Vita Physicien: this certifici	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▷ No	pital: X Inpatient 2 El	R/Outpatien	t 3 🗆 DOA	Othor			Check only or		Other (Spe	cutu)	
n of ng Phys		the state of the s		28b. Time of Injury		c. Injury a	at	28	d. Describe h			0.197	
Division of Vital Records, to attending Physicien: The law requires I after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne, farm, stre	eet, factory,		es 2□N				Number or Ru	ural Route Number.	
Hospitel or 4 hours after Funerel Directel Directel Filled in E		4 E HOMICIGE	building, etc. (Specify)						City or Tow				
Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) Certifying Physics Check only one)	on: To the best of my knowless On the basis of examination and manner stated.	on and/or inv	estigation, in	n my opii	nion, death	n occurred	d at the time, d	aues(e) a late and p	lace, and due	to the cause(s)	
To t To t com	Σ	29b. Signature and title of certifier			29c.	License	J Z	72	_	9d. Date	signed (Monti	h, Day, Year)	
3H-J.		30. Name and address of person who comp	pleted cause of death (Item 2	23a) (Type,	Print)	<i>+</i>	14	ha	11.1	2.1	700		
St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	1		(1	1	prod.				
Regist	rar	JUN 1 4 200	10 terem	B. A.	oute								

			For Stete Registrar	State of Man		artment of He			ene 2005	20243			
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death			
	Physicia /Medic		Ada Florence Ke	ener Strit	е			LINE	10, 200	5:59 AM			
	Examin		4a. Facility Name (If not institution, give s		3	4b. City, Town, or Lo			4c. County of Death Washington County				
			Washington Coun				gerstown If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign				
	Funeral Director		1 🗆	37_	n yrs. last birthday) 87 Yrs.		Hours Min.	Year) Co	aryland				
			213-80-5880 Usual Residence of Decedent	l				Dec 24					
	irylan show	_	10a. State 10b. County Maryland Washing		oc. City, Town or Lo Hager	stown				10d. Inside City Limits 1 ☐ Yes 2 No			
	he Ma 18a-1 o	ecto	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co				
	with t	Funeral Director	14014 Marsh Pik	Δ		217	742	1.0	U.S.	•			
	ne 23	era		2. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14. Race - Ame	rican Indian,			
36	d within 72 hours after death with the Maryland jiene. r then "naturel", or lieme 23a or 28a-f ehow the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		v	Specify:	Hican, etc.)	Black, White Specify: Wh	ite			
ခု	Phour	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupation	on	. 1	6b. Kind of Business/	Industry			
215	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	kind of work done dur DO NOT use retired)	ring most of work	ng		Davidance			
2	77 75 10 10	Com	8	,	Ho	memaker				Residence			
Maryland 21215-0036	d 2 should be filed th and Mental Hygi it is marked other traumatic event, I	Be	17. Father's Name (First, Middle, Last) John B. Keener			1		e (First, Middle, M Pitsnogle	aiden Sumame) e Keener				
2	2 should be and Mental is marked o	ို	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailii	ng Address (Street and			City or Town, State, 2	Zip Code)			
	nd 2 salth ar 27 is r trau		Stephen Strite (s	on)	21327	7 Old Forge	e Road H	agerstow	n Maryland	21742			
J.e.	iges 1 and 2 it of Health : if item 27 or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	- 1	20b. Place of Dispo cemetery, crei	esition (Name of matory or other place)		Date 2	toc. Location - City or				
<u>E</u>	crtent: Hege crtent: If crtent: If injury or		4 Donation 5 Other (Specify)	emoval from State		ırch Cemete	- 4	6–06		g Maryland			
Baltimore,	permit. Peges 1 Destrement of H Importent: If ite any injury or ot one.		21 Senature of Funeral Service License	1 Tury					Fiery Fune stown Mary	ral Home land 21742			
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7	Physician		Immediate Cause (Final disease or condition		cardial	Inta	rction	`		Onset and Death			
1	/Medical Examiner		resulting in death)	Due to (or sac	1	11 +	Fail						
	Examino.	<u>-</u>	Sequentially list conditions, b	Due to (or as a.c				NT C		_			
-	nted I Insit	Examine	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events		ebval	Intar	ct						
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	res thel igned t be det	by P	Part II. Other significent conditions con	tributing to death but r	not resulting in the u	nderlying cause given	in Part I.		acco use contribute to				
ord	w require been si should b	ted	Diabil	15 10	ellitu	ζ'		1 🗆 Ye	s 2 □No 3 □Pr	obably 4 Donknown			
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Z.	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	o∏ EB(Outestie	Other		h (Check only one		-4.1			
ō	Phys arthis aral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Y		II 3LI DON	4 Nursing no	28d. Describe ho	nce 6 Other (Spe winjury occurred	ciry)			
<u>o</u>	ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(eer) Injury		es 2 No						
Division	or Atterder des Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st (Specify)	reet, factory, office		28f. Location (Str City or Town,	eet and Number or Ru , State)	ıral Route Number,			
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		sician: To the best of r ner: On the basis of es and manner state	kamination and/or in								
	o the o the omple	Med	29b. Signature and title of certifier	and mainer state	.	29c. License		29	9d. Date signed (Mont	h, Dey, Year)			
	r s r ö		> Jaim mu	shed		906	50396		06/12/	06			
5	11-11		30. Name and address of person who co	empleted cause of dea	th (Item 23a) (Type	Print) 112	6 opa) ct	n 117	40			
1	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	14	og (> To	, , , , , , , , , , , , , , , , , , ,	7 11	7			
	Regist	rar	JUN 1 4 21	006	10	1-1.							

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

JUN 1 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 1208 AM John Lester Semler III 2006 June Il Under 1 Year Hours Min. S. Date of Birth (Month, Day, Year) 12/17/1938 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington 9. Birthplace Country) 5. Social Security Number 6. Sex State or Foreign 7. Age (In vrs. last birthday) 1 € M 2 □ F Months 220-34-0773 67 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 410 Bethlehem Court US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ™ Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Of Hagerstown Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Lester Semler Jr. Florence Marie Schoultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy M. Semler / Wife 410 Bethlehem Court, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/14/2006 Hagerstown, MD Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancrea Coma Omonth Due to (or as a consequence of): Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time ol death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown MOR Sendomono 1 ☐ Yes 2 ☐ No 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 221 1 ☐ Yes 2 ☐ No 1 ☐ Yes No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner To this Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To this Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlanist completely filled in by the funeral director, page 2 should be detached for use as the burlant transit. Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Completed by Funeral

Funeral

Director

?? is marked other than "natural", or items 23a or 28a-1 shov traumatic svent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 2 and hy Injury or other traumatic svent, the Medical Examinant must be 12 ans.

Physician

/Medical

Examiner

Physician/Medical

Completed by

Be

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Certification;

Medicai

29a, Certifier

29b. Signature and title of certified

31. Date filed (Month) Day

Ham da

Baltimore, Maryland 21215-0036

the Maryland

State Registrar

DHMH 17 Rev 1/2001

who completed cause ol death (Item 23a) (Type, Print)

and manner stated.

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

M

	•	•	1- State of Maryland / Dep Registrer Ce	artment of Health and Mertificate of Death		ene 3. No. 2 0 0 5	20246		
Κ.	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last) Ethel Elizabeth Stotler		Junte 8	2006 Year	3. Time of Death 2:20 P		
E AND	Examin	2 4	4a. Facility Name (If not institution, give street and number) 1501 Dogwood Road	4b. City, Town, or Location of Death St. Leonard		4c. County of Death Calvert			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 78 1 N Age (In yrs. last birthday 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1) August 2	rear) Cour	place (State or Foreign htry) shington DC		
	aryland •how	2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Marvland Calvert St. Leon			1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	with the M s or 28a-f be nutified	Direc	Maryland Calvert St. Leon 10e. Street and Number 1501 Dogwood Road	10f. Zip Code 20685	10	10g. Citizen of What Country? United States			
36	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene defects than "natural", or items 23a or 28a-f ehow of other than "natural", or items 23a or 28a-f ehow event, the Madical Examiner must be natified at	by Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W			
Maryland 21215-0036	l within 72 hou iene. r then "neture it e Mcolcal E	Completed	(Specify only highest grade completed) (Giv. life.	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) emaker	ng 1	own home	dustry		
land	should be filed and Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) William Francis Harper	18. Mother's Name Mollie H		aiden Sumame)			
Mary	ith 27 in tra			ling Address (Street and Number or Rura King Dr. Dunkirk N		City or Town, State, Zip	Code)		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury or other tri ance.		20a. Method of Disposition 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	position (Name of ematory or other place) Cemetery June 12 20	006 Ba	oc. Location - City or To arstow Mary			
Balt	permit. Departimport. eny inj		eral Home epublic MD	20676					
8760,	death certificate be executed e attending physician and correspond to the corresponding to t	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expect the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-	S em	d Stage	Approximate Interval Between Onset and Death		
.O. Box 68	death certifi e attending ed for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year		
<u>α</u>	the bear	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		23d. Date of delivery Month Day Year co use contribute to the cause of death? s 2 \[\text{No} 3 \] \[\text{Probably} 4 \] \[\text{Unknown} \]			
I Records,	The law requires ate has been sign page 2 should be	Completed			24a. Was an autopsy perform	ed? prior to co	mpletion of cause of		
of Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 1 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manny 1 Death 28a. Date of Injury 28b. Time		me 5 Resider	nce 6 Other (Special	(y)		
Division	I or Attending I after death. Director: After I in by the funer	Certification:	1 - latural 5 Pending Investigation 3 Suicide 4 Homicide Homicide (Month, Day Year) Injury - At home, farm, suiciding, etc. (Specify)	Work? M 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number Of Town, State)				
	To the Hospital within 24 hours at To the Funeral Completely filled in	Medical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or						
	To the within 2 To the complete	Med	29b. Signature and title of certifier Action 1. Signature and tit	29c. License number	29	d. Date signed (Month,	Day, Year)		
	15		30. Name and address of person who completed cause of death (Item 23a) (Type K Yazdani MD Huntingto						
	Sta Regist		31. Date filed (Month, Day, Year) : 32. Registrate Signature JUN 1 3 2006	Sparle					

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Daniel Vincent Staib 20247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0931 hrs **Medical Examiner** June 20, 2006 Daniel Vincent c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center Harford If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min Director CountryMaryland 214-17-3166 1 XM 23 1983 2 F Yrs May 15, Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits 10a State 1 Yes 2 XNo or 28a-f show Maryland Harford Joppa notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 206 Chell Road 21085 23я 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married Armed Forces? 2 X No Yes Yes 2 No specify: after Divorced If Yes, Give Year Specify: 3 Widowed White "natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 | and Mental Hygiene is marked other than 'atic event, the Medical Baltimore, MD 21215-0036 Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Linda Ann Baker Faber Staib, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages I and 2 shument of Health and rtant: If item 27 is Donald F. Staib / Father 206 Chell Road, Joppa, MD 21085 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: I 6-24-06 Gardens of Faith Cem. Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee E, Marki Maryland 21009 7 Cokesbury Road, Abingdon, 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Methadone intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED item#23a,27,28a-f,perME,g856,6/28/06 TT XXUNPENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown the signed by the detacher Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? After this certificate has ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes ၉ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year 1 Natural Division 1 Yes 2 X No 5 Pending FNd 6/20/2006 Fnd 8:30 am unknown Director 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 206 Chell Road determined (Specify) Found at residence Joppa, MD Fo the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title O.C.M.E. June 21, 2006 completed cause of death (Item 23a) 30. Name and add ss of person who Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Rople MD. 31. Date filed (Month, Day, Year) State IIIN 2.7

DHMH 17 Rev 1/2001 OCME 2006

Registra

	1.	For State Registrar	State of Maryland		ate of Death	Re	g. No. 2 U U C	20240	
ian	*	Praire (First, Middle, La.		TT.		2. Date of Death Month June	Day Year 20 2006	3. Time of Death	
ner	4a	i. Facility Name (If not institution, given Washington Cou	e street and number)		City, Town, or Location of Dea Hagerstown	th	4c. County of Deal	th	
		Social Security Number 6. S	ex 7. Age (In yrs. lasi XD M 2□ F 87	Yrs. Mon	nder 1 Year If Under 24 Hr ths Days Hours Mir		^{9. Bin} 1919 Ma	thplace (State or Foreign puntry) ryland	
tor	10 N	Da. State 10b. County Maryland Freder	ick 10c. City, T	own or Location Frederic	.k			10d. Inside City Limits 1 X Yes 2 No	
Funeral Director	10	De. Street and Number 1001 Carroll Par	kway, # 110	101	Zip Code 21 7 01	10	og. Citizen of What Co		
À		1. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 15 Yes 2 No 1943 If Yes, Give Year or Dates: 1965	-	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify:		
Completed	_	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation dide completed) College (1-4or 5+)	6a. Decedent's (Give kind o life. DO NO Pilot/N	Usual Occupation f work done during most of w OT use retired) illitary Airli	orking ft Com	6b. Kind of Business, U.S. Air	•	
To Be C	17	7. Father's Name (First, Middle, Last, Francis Xa	vier Staley	Sr	18. Mother's Na Flore	me (First, Middle, M		amar	
		9a. Informant's Name/Relationship (Tracy Staley Sch		-	ress (Street and Number or F ames Street,				
	20	Da. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	cem	e of Disposition etery, crematory	(Name of or other place) at 1 Cemetery	1	0c. Location - City or		
ilcal Examiner	Ir do	23a. Part1. Enter the disease, or com shock, or hear failure. List only mmediate Cause (Final lisease or condition esulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Last		ice of):	tory Fail	,		Interval Between Onset and Death	
Physician/Med	1F 2	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 Ectop	ic pregnancy r (specify)		23d. Date of del Month	ivery Day Year	
þ	ר ר	an II. Other significant conditions of	contributing to death but not resulting		-	23e. Did toba	acco use contribute to s 2 ☑No 3 ☐ Pr	the cause of death?	
Completed	_	('				24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	atopsy findings available completion of cause of 2□ No	
o Be	1	 Was case referred to medical examiner? 1 Ø Yes 2 □ No 	Hospital: 1 Inpatient 2 ER	VOutpatient 3	100	eath <i>Check</i> only one Home 5 ☐ Resider	nce 6 Other (Spe	cify)	
Certification: T		7. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not b	(Month, Day Year) Tune 16, 2004 (Bb. Time of Injury プゴはし M	28c. Injury at Work? 1 ☐ Yes 2 ☑ №6	28d. Describe hov		/	
		4 Homicide determined	building, etc. (Specify)			1 of the or Lown	eet and Number or Ru State) Liuik WC	Ant 100	
	2	9a. Certifier 1 ☐ Certifying Ph (Check only 2 ☑ Medical Exar	nysician: To the best of my knowle niner: On the basis of examination and marmer stated.	and/or investiga	red at the time, date and plac tion, in my opinion, death occ	urred at the time, da	use(s) and manner as te and place, and due	to the cause(s)	
dica		d. Date signed (Monti							
Medical	2	9b. Signature and utle of certifier	DIHOTEMA		10-1062	- 3	Tune 21		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registramend #12 Per FH C857 7/17/06 Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Edward 20 0020 M Franklin 16 Suit /Medical 4c. County of Death

AUE GAN 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nar. 23, I Beapock Campus 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1፟፟M 2□ F 577-40-7249 79 Virginia Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4816 Dry Run Road 21561 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May 15 No. If Yes, Give Year or Dates: WWIII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair Service Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Heelth and Mental H lant: If item 27 is marked other Lawrence Suit Hilda Highlander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorcas V. Suit/ Wife 4816 Dry Run Road, Swanton, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or onco. Uber-Fazenbaker Cem. 6/18/06 Swanton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician dal resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con Examiner The law requires that the death certificate be executed for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, page 2 should be 1 ☐ Yes 20 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No r death. actor: After this certifice by the funeral director, p Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendit within 24 hours effer death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - PHA au MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PWR (sh 31. Date filed (Month, Day, Year) JUN 16 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () () For State
Registra MFND#24aperMD6/12/06, EMW, McCo Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 5, 2006 June 12:15P Solomon Murie1 /Medical 4c. County of Death 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 12013 Winesap Terrace North Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3-15-1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours New York 1 ☐ M 2 1 F 073-26-8433 Yrs 74 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c City Town or Location 10a. State MD North Potomac 1 Nes 2 No Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20878 12013 Winesap Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Media Center Specialist 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: if flem 27 is marked othen any injury or other traumatic event space. Be Rebecca Weinstein 2 Harry Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12013 Winesap Terrace N. Potomac, MD 20878 Benjamin Solomon-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ⊠Removal from State Falls Church, VA 6-7-06 King David Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and representative Goldberg Memorial Chapels, Inc. 21. Signature of Furteral Service Licensee 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate
Interval Between
Onset and Death
Days Immediate Cause (Final disease or condition resulting in death) Pulmonary Failure Proysician /Medical Due to (or as a consequence of): Chronic Obstructive lung Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 ☐Unknown Cancer of Lung Cigarette Smoking 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending investigation 1 Yes 2 No М 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit Records, P.O. page 2 should has of Vital director, this Alter thi funeral of Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Alte completely filled in by the fun

Funeral

r then "natural", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at

with the Maryland

death

filed within 72 hours after

other 1

Baltimore, Maryland 21215-0036

Box 68760,

State Registrar

Schwartz Stanley A. 31. Date filed (Month, Day, Year) 12 JUN 2006

29b. Signature and title of certifier



20

29c. License number

D 17368

29d. Date signed (Month, Day, Year)

June 7, 2006

		-	For State Registrar	State	of Mary	land / Dep	oartmer e <i>rtifica</i> :	nt of H	ealth and Death	Mental I	Hygie _{Reg.}		06	20251
		C. T.	Decedent's Name (First, Middle	e, Last)						2. Date o	f Death			3. Time of Death
	Physici	an								Month		2006	Year	C. 10 D M
	/Medic		Talcott Willia 4a. Facility Name (If not institution				4b. City	, Town, or	Location of Dea	June	0,	4c. County	of Death	6:49 P ^M
	Examin	er			,				_					
1 41	F		5510 Pembroke 5. Social Security Number	Koad 6. Sex	7. Age (Ir	yrs. last birthda	y) If Unde	ethes or 1 Year	If Under 24 Hr	s. 8. Date o	f Birth		tgom 9. Birth	place (State or Foreign
	Funeral Director		030-18-3527	1 反 M 2□ F		34 Yrs.	Months	Days	Hours Mir	Mar.	, Day, Ye		Cou	**
	.9		Usual Residence of Decedent			04		1		Mar.	0,1	922	Leba	Hon
	/land		10a. State 10b. County		10	c. City, Town or	Location							10d. Inside City Limits
	Man	호	Maryland Monte	OMARN		Bethesd	9							1 ☐ Yes 2 反 No
	r 28a	Director	10e. Street and Number	Omery		Decheso		ip Code			10g.	. Citizen of	What Cou	ntry?
	hours after death with the Maryland turel", or tleme 23e or 28e-f ehow at Exanications to notified at		5510 Pembroke	Road					20817			USA		
	me 2	Funerai	11. Marital Status	12. Was D	ecedent Eve	r in U.S. 1	3. Was Dece	edent of Hi	spanic Origin? (Specify Yes o	r No-	14. Ra		can Indian,
0	r ft		1 ☐ Never Married 2 🔀 Marr	ned 1 📆 Ye	Forces? s 2 ☐ No				n, Mexican, Pue	ento Hican, etc	.)		ck, White	etc.
2	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Year o		WII	1 ☐ Yes	2LX.No	Specify:			Specii		ite
9500-61212	2 ho	Completed	15. Deceden (Specify only higher	it's Education	nd)	16a. De	cedent's Usi	ual Occupa	ation during most of w	orkina	16	b. Kind of 8	lusiness/lr	ndustry
	hin 7	pie	Elementary/Secondary (0-12)		e (1-4or 5+)	lite	DO NOT	use retired)	UIKIIIG				
	d wit	МО	, (,	5+		Fore	ign Se	rvic	e Offic	er	Fε	edera]	Gov	ernment
g	oth oth	Bec	17. Father's Name (First, Middle,	Last)			0		18. Mother's Na		ddle, Mai	iden Sumar	ne)	
<u>a</u>	lid be lenta ked ked	5	Laurens H. S	eelve					Kate	Chaml	ers			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exacting and the notified at once.		19a. Informant's Name/Relations			19b. Ma	iling Addres	s (Street a	and Number or F	Rural Route N	umber, C	ity or Town	, State, Zi	Code)
Š	alith a		Joan H. Seely	P	Wife	5510	Pembr	roke	Road R	ethesda	Me	rular	d 2	0817
Baltimore,	THE BE		20a. Method of Disposition		12	20b. Place of Dis	position (Na	ame of		Date		c. Location		
<u> </u>	t: Ti		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State	Metropo	litan	outer plac	T	10 200			1	
들	rtan njur	1	21. Signature Fineral Service					nator	y Jun	.10,200	O AL	Lexand	ırıa,	Virginia
e B	Deprin		Mobesto	Kam	164		Franci	Lṣ J.	colling	s Funer	al F	lome,	Inc.	ID 00001
_			23a. Part1. Enter the disease, or										ring	MD 20901 Approximate
			shock, or heart failure. List	only one cause of	on each line.	deam. Do not	enter tre mic	de or dynn	g, such as cardi	ac or respirate	ny allost	,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a Car	diopul	monary .	Arrest							5 months
	/Medical Examiner		resulting in death)			onsequence of):								
	LAditifie		Sequentially list conditions,		umonia									$1 \cdot 1/2$ weeks
40	₽ ∺	ner	if any, leading to immediate cause. Enter Underlying	Due	to for as a co	onsequelice of).								
	nd	Examin	Cause (Disease or injury that initiated events			Neutro	enia							1 month
Ö,	icate be executed physicien end s the burial-transit		resulting in death) Last	Due	to (or as a co	onsequence of):								
8760,	ate b nysic he bi	dicai		d									_	
9	ng pl	Sed	IF FEMALE:	1								1		
Вох	death certifi e attending I ed for use as	Physician/Me	23b. Was decedent pregnant		outcome of p		3 □Ectopic	oregnancy				1	ate of deliv	,
	deal	ici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	egnant at tim		5 Other (s				_	M	onth	Day Year
o.	that the de led by the a detached	hys	9 Unknown	300	KIIOWII									
	The law requires that the tite has been signed by thogge 2 should be detache	by	Part II. Other significant conditi	ons contributing t	o death but n	ot resulting in the	underlying	cause give	en in Part I.	23e.	Did tobac	co use con	tribute to	the cause of death?
ğ	w require been sig should b		Pancreatic	Cancer							1 🗆 Yes	2 🙀 No	3 ☐ Pro	bably 4 □Unknown
Records,	s bee	Completed									Was an	24b.		opsy findings available
æ	The lavate has	E									autopsy performe		death?	empletion of cause of
Viital		Ö	25. Was case referred to medica						26. Place of D		es 25	No	1 🗆 Yes	2LI NO
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ō	Phys rthis ral di	H	27. Manner of Death	28a. Da	ate of Injury	28b. Time		28c. Injun Wor				injury occu		(y)
on	Attending Phir death. ector: After the	tion	1 XNatural 5 Pendi	ng (A igation	Aonth, Day Ye	ea <i>r)</i> Injur	y M		k? Yes 2∐No					
S	death death ctor: /	lica	3 Suicide 6 □ Could	not be	ace of Injury	- At home, farm,	street, facto	orv. office		28f. Locat	on (Stree	et and Num	ber or Rui	al Route Number,
Division	or Attendation of Director:	Certification:	4 Homicide determ	nined 286. Pi	uilding, etc. (Specify)		.,,		City o	r Town, S	State)		
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyi	ng Physicien: To	the best of n	ny knowledne de	ath occurre	d at the tre	ne, date and pla	ca. and due to	the caus	se(s) and m	anner as	stated
	Hos 24 h Fun Fun	edical		Exeminer: On th		amination and/or								
	thin :	Med	29b. Signature and the of certific		^		2	9c. Licens	e number		29d	. Date signe	ed (Month	Day, Year)
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١	211		Lan	- Cen	7	Lei	n	14:	398		Ju	ne 9,	200	5
			30. Name and address of person											
	ma Test		Lawrence Elli	ot Klein	M.D.	3301	New M	lexic	o Avenue	e,NW_W	ashi	ngton	,DC	20016
	Sta Regist	ate	31. Date filed (Month, Day, Year JUN 1	2 2006	2. Registrar's	Signature	docath	,						
٤,	negisi	ग्या	0011 1	- 2000	MELLES-	1 10 1								

	1		For State Registrar		State	of Maryla	and / Depa	artment <i>rtificate</i>			ind M	lental H	lygier Reg. I	60	06	202	52
	Physicia	an	Decedent's Name (Fire Mary	st, Middle, La	ast) E			Sesso	ms			2. Date of Month June	Death 7	^{Day} 200	6 ^{Year}	3. Time of D	eath M
	/Medic Examin	5	4a. Facility Name (If not i	institution, air				4b. City, T		Location of	f Death		4c. County of De				
1	∈xamın	er	Anne Arund	_				An	napo	lis			Anne Arunde			ınde1	
	Euporol	aven.	5. Social Security Number		Sex		rs. last birthday)	If Under 1	Year	If Under 2		8. Date of	Birth			place (State or I	coreign
	Funeral Director		167-20-589	96	1 □ M 200 F	9.	5 Yrs.	Months	Days	Hours	Min.	June	22 , 22	910	Nort	h Carol	lina
	D .		Usual Residence of Dece			1.0											
	unylar show dat	L.		. County		106.	City, Town or Li								,	I0d. Inside City 1 ☐ Yes 2	
	s 1 and 2 should be blied within 72 hours after death with the Marylan f Health and Mental Hygiene. I fleatht and Mental Hygiene the fleath of its marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be natified at	Funeral Director		Anne A	rundel		Croft						-T"				12110
	vith th	Dire	10e. Street and Number					10f. Zip (Code 2111	,			10g.	Citizen of V		ntry?	
	s 23e	rai	1733 Swint	ourne .					-4	<u> </u>	US.		can Indian,				
	er de item	nue	11. Marital Status 1 ☐ Never Married	O Massind	Armed F	cedent Ever in Forces? 2 2 No	10.5.	Was Decede If Yes, specif	fy Cubar	n, Mexican	, Puerto	Rican, etc.)	No-		k, White,		
36	rs aft	by F	3 X Widowed 4 □I		If Yes, G	ive		1 ☐ Yes 2	X No	Specify:				Specify	″ B1	Lack	
Ö	72 hours after death with the Maryland natural', or items 23e or 28e-f show digal Examiner must be notified at	ed	15. 1	Decedent's 8	ducation		16a. Dece	dent's Usual	Occupa	tion			16b.	Kind of Bu	usiness/In	dustry	
15	n n n	Completed	(Specify or Elementary/Secondary	-	rade completed	(1-4or 5+)	(Give	kind of work DO NOT use	(done di e retired)	u <i>ring</i> most	of worki	ng					
212	d within giene. rr than	E O	12	(0-12)	College	(1-401 54)	Nani	ny						Home	Care	2	
Þ	e filed within al Hygiene. I other than '	0	17. Father's Name (First,	Middle, Las	t)					18. Mothe	r's Name	(First, Midd	die, Maid	en Suman	ne)		
Maryland 21215-0036	2 should be and Mental is marked o aumatic eve	ToB	William F.	Ho11	oman					Man	ry V	ictori	La				
an	2 should and Men is marke		19a. Informant's Name/F	Relationship	(Type, Print)		19b. Maili	ng Address ((Street a	nd Numbe	r or Rura	il Route Nur	nber, Cit	y or Town,	State, Zip	Code)	
Σ	and 3 ealth n 27		Frank Goul		n-in-la		and the same and	3 Swin		ne Ave		-	_				
ore	of He		20a. Method of Disposition 1X Burial 2 □ Cre		Bemoval from		 Place of Dispersion cemetery, cre 	osition (Name matory or oth	e of her place	9)		Date	20c.	Location -	City or To	own, State	
Ē	Pag ment ant: i		4 □Donation 5 □				den Cem	etery			6-14	-2006	Co	ollin	gda1e	PA PA	
Baltimore,	permit. Pages 1 and Department of Heall important: if item 2 any injury or other once.		21. Signature of Eugeral	Service Lice	ensee /		2	Name and Harde 12 Ri	sty	Fune	ral	Home, Anna	P.A.	is, M	D 214	101	
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	(a. Cor	Onoty o (or as acons	sequence of):	y di	ten	le						Onset and De	nath
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Vital	tific tor,	Be	25. Was case referred to examiner?	medical					octors :-	26. Place	of Death	Check on				-6-	
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	ding P. h. After t	i.	27. Manner of Death 1 Natural 5	☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year	28b. Time of Injury		Bc. Injury Work			28d. Describ	e how in	jury occur	red		
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	To the Hospitel or within 24 hours after To the Funeral Director completely filled in the Funeral Director Completely filled in the Funeral Completely filled in the	edical	29a. Certifier 150 (Check only 2 one)	Certifying P Medical Exa	iminer: On the	he best of my basis of exam inner stated.	knowledge, dea nination and/or in	h occurred a ivestigation,	it the tim in my op	e, date and inion, deat	d place, th occurr	and due to ti ed at the tim	he cause ie, date a	(s) and ma and place,	and due to	tated. the cause(s)	
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			30. Name and address	person who	completed ca	use of death (Item 23a) (Type			1		-	1	A	D.	MD210	<i>c.</i>
			Da feet	Singh	Sica	free 1	10 208	Crai	in	Tighw	sty,	S.W.	. Ola	n Bur	nie	MD210	06)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 4:00 Am **Physician** 05 2006 Shirley Marie Southerland JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel FutureCare Chesapeake Arnold If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🛛 F 81 Jul. 4, 1924 219-16-5309 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or itams 23a or 28a-f show ury or other traumatic event, the Mcdical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yas 2 No Director Arnold Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21012 305 College Parkway USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: Specify. altimore, Maryland 21215-0020 If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home/Restaurant Homemaker/Waitress 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Winters Margaret Wagner 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Lockard/Son 231 North Beaumont Ave., Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jun. 7, 20a Method of Disposition Elkridge, MD 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. Meadowridge Memorial Pk. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD sations that eached the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate O use (Final disease or indition resulting in death) /Medical a. METASTATIC CARCINOMA, UNKNOWN
Due to (or as a consequence of): PRIMARY Examiner Physiclan/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco usa contributa to the causa of death? a signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No (MRONIC OBSTRUCTIVE PULMONARY DISEASE þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificete hes been si funeral director, page 2 should Completed PNEUMONIA 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation ours efter death. eral Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stare) 3 Suicide 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

8601 Veterans May, Millersville, ND 21108

State Registrar 31. Date filed (Month,

, Mi)

32. Projistrar's Signature

30. Name and address of pessen who completed cause of death (Item 23a) (Type, Print)

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JUN 0 9 2006

				artment of Health and N Dodhb ertificate of Death	Heg.	ne 006 20254
	Physicia		Decedent's Name (First, Middle, Last) T		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Marigene H. Stiefel		June	10, 2006 10:06 P M
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Country Meadows	Frederick		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 o /.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director	}	Usual Residence of Decedent		10/03/19	Zl Ohio
	and	ł	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary	ō	Maryland Frederick	Frederick		1 ☐ Yes 2 📉 No
	the 28a	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3e o		5955 Quinn Orchard Road	21704		United States
	ms 2	Funerai		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
و	after or Ite	F	1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never No WW II	1 ☐ Yes 2 ☑ No Specify:	7 110411, 010.)	Black, White, etc. Specify: White
9	ural'.	d by	3 Wildowed 4 □ Divorced Year or Dates:			Specify: White
2	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. ad other than "natural", or items 23e or 28a-f show adother than "natural", or items 23e or 28a-f show event, I're Maryland Extrainment and the motilified at	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of wor	king 16t	b. Kind of Business/Industry
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7	filed withi Hygiene. other thar ent, the M	ပိ	17. Father's Name (First, Middle, Last)	ealtor 18. Mother's Nam	ne (First, Middle, Mai	Real Estate
Maryland 21215-003	ed ital	Be c	John M. Hoke		Mary Shane	er
2	2 should be and Mental is marked c	ို		ling Address (Street and Number or Ru		
<u>B</u>	and 2 s lealth ar m 27 is her trau		1 1 1 1	Travener Circle,		
altimore,	T 00 =		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date 200	Location - City or Town, State
e E	Pages nent of i int: If It		1 Burial 2 Extremation 3 Elemoval from State		/2006 F:	rederick, Maryland
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m	Depar Impo		(outners) Stoulder	1621 Opossumtown H	ike, Fred	erick, MD 21702
			23a. Rart 1. Enter the disease, or complications that caused the death. Do not en shoek, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician	. 0	Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner	L	Sequentially list conditions, b.			
	ed sit	Examiner	If any, leading to immediate cause. Enter Underlying Cause, Underlying Cause (Units as a refur)			ļ
	and and Il-tran	хап	that initiated events c. Due to (or as a consequence of):			
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687	ficate physics the	edic	0.			11
Вох	leath certifica attending ph I for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	Пс. м. і		23d. Date of delivery
m.	death e atte	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P. O.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	9 Unknown			
	res tha igned I be det	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
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Lo	ding I h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation			,,
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
ă	al or A s after if Dire	Serti	4 Homicide determined building, etc. (Specify)		City or Town, S	itate)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (Ch			
	he Hi in 24 he Fi plete	edical	one) and manner stated.			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
l	AVI		My.)8060417	6	7002/211
	P,		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	7.10.1.	21702
			31. Date filed (Month, Pay, Year) 32. Engistrar's Signature	Janksan SV	TYTHEN	ICK MIS
	Sta Regist		JUN 1 3 2006	gove		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12 130 PM **Physician** I une 200 Glynn Michael Stansbury /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rising Sun
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Cecil Deer Ridge Manor Assisted Living Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day,)
Dec. 20, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 **X**M 2 ☐ F Year **Funeral** Dec. Alabama 420-44-0385 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Cecil Rising Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21911 USA 1126 Ridge Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1955-58 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "nt eny injury or other traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) Medicine Chiropractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Vera Byrd Cami Stansbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 McGrady Road, Rising Sun, MD Glynda Leonard/daughter 06-12-2006 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t X Burial 2 □ Cremation 3 □ Removal from State Nottingham Missionary Baptist Cemetery Nottingham, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 111 S. Queen St. Rising Sun, MD ichaso Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, caused the 23a. Part1 Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease of condition resulting in death) ocen 5 Physician Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate name. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by Physician/Medical Examiner or Attending Physicien: The law requires thet the death certificate be executed attending physicien end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 Nunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete hes al director, page 2 1 ☐ Yes 2 ☐ No 1 Yes 200 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Other: 4 Nursing Home 5 Residence 6/10ther (Specify 1551) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (a sons 45 5+1VA 32. Register's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

		-	For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment rtificate	t of Health a e of Death	and M	lental Hy	giene Reg. No.	2006	20256
	Dhysisis		1. Decedent's Name (First, Middle,							2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic	al .	ARTHUR	С.		SIMON				June	11,	2006	7:30 A M
	Examin	er	4a. Facility Name (If not institution,	-				Town, or Location			4c. (ounty of Death	
			8219 Morning					rederick				Freder	
	Funeral			6. Sex 1 XM 2 ☐ F	7. Age (In yrs. 87	Yrs.	Months	Days Hours	Min.	8. Date of Bit (Month, Da	ay, Year)	Cou	place (State or Foreign Intry)
	Director	-	162-10-3782 Usual Residence of Decedent		0/					SEPT.	4,191	8 ren	nśylvania
	ow (10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
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:	r 288	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What Cou	intry?
	39 O	ai D	8219 Morning	Dew Co	urt			21702			Unit	ed Sta	ates
	dear	Funerai	11. Marital Status	12. Was De	ecedent Ever in U Forces?	I.S. 13.	Was Deced	lent of Hispanic Or ify Cuban, Mexica	igin? (Spe	ecify Yes or No	o- 1	4. Race - Ameri Black, White	
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215-0036	illed within 72 hours after death with the Maryand Hygiene, wither than "neturel", or Items 23e or 28e-f show shit, the Medical Evantiner must be rediffed at	d by	3 Widowed 4 Divorced	Year or	Dates:								
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מ ס	Hygi Hygi Sther ent, I	ပိ	17. Father's Name (First, Middle, L	.ast)			порог			(First, Middle	, Maiden S	Sumame)	
<u>a</u>	should be nd Mental marked o umatic eve	To Be	Thomas	Henri	cks S	Simon		M	ary	Jane	Ca	mpbe11	
	shour nd M mar	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address	(Street and Numb	er or Rum	i Route Numb			p Code)
Ž	is 1 and 2 should be filed within 72 hours after death with the manyfan of Health and Mental Hygiene. If Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23e or 28a-1 show other traumatic event, the Medical Evantiner must be recilified at		Ann Simon / Wi	fe		8219	Morn	ing Dew	Ct./	Freder	ick,	Marylan	nd 21702
Ze			20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Damoval fro	20b. I	Place of Dispo cemetery, crei	sition (Nan	ne of ther place)		Date	20c. Loc	ation - City or T	own, State
Ĕ	permit. Pages Department of I Importent: If its any injury or o		`4 □ Donation 5 □ Other (Sp		Re	sthaver	n Mem.	Garden 0	6/15	/2006	Fred	erick,Ma	aryland
<u>a</u>	srmit. sparti sport ny inj		21. Signature of Funeral Service L	icensee		22	2. Name an	d Address of Facil	ity Sta	uffer	Funer	al Home	s, P.A.
_	10 2 2 0 1		Maymond	Dele	rson			possumto				ck, MD	21702
n.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause of	it caused the dea n each line.	th. Do not en	ter the mod	e of dying, such as	s cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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89	tifical ng phy as th	Medi	le sever s										
Вох	death certifica attending ph of for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregne birth 2 Teta		∃Ectopic pr	egnancy			2	3d. Date of deliv	*
о Ш	e dea he att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No		gnant at time of		Other (sp					Month	Day Year
<u>Ч</u>	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as I	Phy	9 ☐ Unknown Part II. Other significant condition	ne contribution to	doath but not ro	nulting in the u	a dark ion o	auga auga in Dad		230 Did	tobacco us	o contributo to	the cause of death?
က်	ires tha signed l	by	Faith, Other signmount contains	ins contributing to	COMIT DUTINOT TO	saking in the c	indentying c	ause given iii i arc			Yes 2		bably 4 Unknown
0	w require been si should I	etec			-								
Record	has has by	Completed								24a. Was		prior to co death?	opsy findings available ompletion of cause of
			OF Management to market							1 L Yes	ZINO	1 🗆 Yes	2 No
Vita	sicie certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	☐ Inpatient 2☐] ER/Outpatie	nt 3 🗆 DC	Other		Check only		Other (Speci	
of	Attending Physicien: The lav r death. ector: Alter this certificate has by the funeral director, page 2	H	27. Magner of Death	28a. Da	te of Injury	28b. Time o		8c. Injury at Work?		28d. Describe			nyy
ion	nding ath. r: Afte e fun	atlo	1 Natural 5 Pending	9	lonth, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐]No				
Division of	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Pla	ace of Injury - At I	nome, farm, st	reet, factory	, office			(Street and	Number or Rui	ral Route Number,
Ö	tel or A	Cer			namy, oto. (opoo						, Oldio)		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2/ Medical	Examiner: On the	basis of examin	owiedge, deat ation and/or in	h occurred vestigation	at the time, date a	nd place, ath occurr	and due to the ed at the time	cause(s) ; date and	and manner as place, and due	stated. to the cause(s)
	To the h within 2 To the f complete	Med	one) 29b. Signature and title of certifier	and m	anner stated.			. License number				signed (Month	
	\$ 1 ₹ £ 8						7	271.00	, ¬		1	13/13/	e)
	AVIE		30. Name and address of person	who completed o	ause of death /Ite	m 23a) /Tuno	Print)	20000	1/		01	10/00	21702
1	10,,		HPM & A CL	ral L		homa	~	bucan	do	GUP	FVA	denic	IL MA
	Sta	ate	31. Date filed (Month, Day, Year)	2 2006 32			back	,		1	1		7-12
	Regist	rar	30N 1	0 5000	The same	- 7							

				-	epartment of Health and I		
		•	For State Registrer		Certificate of Death	Reg.	2006 20257
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Sullistan	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give str	meet and number)	4b. City, Town, or Location of Death	May	4c. County of Death
	Examin	er	The Johns +	lookins Hosp	ibl Baltimore	City	None
	Funeral Director		5. Social Security Number 135–56–2397 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye August 2	9. Birthplace (State or Foreign Montclair, NJ
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location		10d. Inside City Limits
	8a-f sho	ector	Maryland Harford	Bel A			1 ☐ Yes 2 XNo
	23a or 2	Funeral Director	10e. Street and Number 914 Fallen Stone (Court	10f. Zip Code 21014	_	Citizen of What Country? nited States
036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show officel Expenieur, sast be multiped at	b	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade	ation 16a. I	Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired)	king 16b	. Kind of Business/Industry
121		Completed	Elementary/Secondary (0-12)		life. DO NOT use retired) aphic Designer		ecton & Dickenson
Maryland 21215-0036	be filed ital Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Richard Amann		18. Mother's Nan	ne (First, Middle, Maid n Ryan-Amaj	den Sumame)
	2 8 3 8	-	19a Informant's Name/Relationship (Typ John Sullivan	Husband) 19b. 91	Mailing Address (Street and Number or Ru 14 Fallen Stone Cour	ral Route Number, Ci ct Bel Air	ity or Town, State, Zip Code) , MD 21014
Baltimore,	Pages 1 and 3 nent of Health int: If item 27 ing or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Other (Specify)	cemeters	Disposition (Name of t, crematory or other place) I Medical School (ashington, DC
Balti	permit. Pages Department of Important: If it any injuryor o		21. Signature of Funeral Service Licenses	Auto	22. Name and Address of Facility Austin Royster I 3821 14th Street	Funeral Hor	me
U			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do no	ot enter the mode of dying, such as cardiac		Approximate Interval Between
di	Pnysician		Immediate Cause (Final disease or condition	CardioVa	Scular Co	lapse	Onset and Death
	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of Due to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a)	- Cholangioc	arcino	oma 1 year
,092	icate be executed physician and s the burial-transit	cal Exa	resulting in death) Last	Due to (or as a consequence of	f):		
O. Box 68	nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	vrequires that the death been signed by the atte should be detached for	þ	Part II. Other significent conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	w requir been si should I	letec				24a. Was an	24b. Were autopsy findings available
I Re	The lav	Completed				autopsy performed	prior to completion of cause of death?
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Othor	ath (Check only one)	
of	Phys this ral di	on: To	1 Yes 2 No ''' 27. Manner of Death 1 Natural 5 Pending	28a. ate of Injury 28b. T	ime of 28c. Injury at jury Work?	ome 5 Residence 28d. Describe how i	e 6 □Other (Specify) injury occurred
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	e Hospital 24 hours a e Funeral I letely filled	edical C	29a. Certifier 1 Certifying Phys (Check only one)	cien: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occurred.	, and due to the caus irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
)			> X tax U	MD RE	SIDENT RES-000		une 4th, 2006.
				npleted cause of death (Item 23a) (**	_	21287.
	Ç.	ate	31. Date filed (Month, Day, Year)	2 JOHNS HOPILI	MS HOSPITAL, 600 NOS	174 WOLFES	TREST, BASTIMORE, MARYLAM
:	Regist			306 Marie S.	Marke		

			For State Registrar	State of	Maryland / De	partment of lertificate of	Health and Death		giene () (06 20258
- 2	2 8 4		Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ıth	3. Time of Death
	Physicia /Medic		Agnes Marie Tr	upo				June	Day 200	Year 06 6:55 P M
	Examin		4a. Facility Name (If not institution		oer)	4b. City, Town,	or Location of Deat		4c. County of	
4.			5704 Trailview			Frederi			Frede	
¥	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 反 F	. Age (In yrs. last birthd	Months Days	If Under 24 Hrs Hours Min.	(Month, Day	r, Year)	Birthplace (State or Foreign Country)
(c)	Director		578-20-4162 Usual Residence of Decedent		86			April 4	,1920	West Virginia
	yland		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	a-1 et	ctor	Maryland Frede	rick	Fre	derick				1 ☐ Yes 2 ☐ No
	death with the Maryland ims 23a or 28a-f ehow ir mast be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hal Country?
	ath w	ral	5704 Trailview				703		USA	
	er de	Funeral	11. Marital Status	Armed Ford	es?	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American Indian, c, White, etc.
36	I', or	by F	1 Never Married 2 Mar- 3 X Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
ò	2 hou	ted		nt's Education	16a. De	cedent's Usual Occu	pation	4.1-	16b. Kind of Bus	
215	thin 7	Completed	(Specify only night Elementary/Secondary (0-12)	st grade completed) College (1-4	- lif	ive kind of work done e. DO NOT use retire	during most of wo	nking		
7	ygien ygien t, Ine	Con	12		Admi	nistrativ				1 Government
nd	tal H	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame	,)
<u> </u>	ould 1 Men narke	ဥ	James Lawrence		105.14	ailin a dadaaa (Chara	Lillia			7-0-4-1
Mai	d 2 st th and 7 is r traur		19a. Informant's Name/Relations			ailing Address (Street				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or items 23s or 28s-1 ehow any injury or other traumatic svent, the Medical Examinating the notified at once.	1 8	John C. Trupo 20a. Method of Disposition	δ	20b. Place of Di	Maynard sposition (Name of		Date Date	20c. Location - C	City or Town, State
<u>o</u>	ages ant of		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate Gate of	Heaven	CO)	10 2006	Silver	Spring, aryland
Ħ	mit. F partme cortar injur	1	21. Signat e Funeral Service			Cemeter 22. Name and Address	ass of Facility	10,2006		-
ä	P P P P P P P P P P P P P P P P P P P		(inche.)	Col	Q.	rancis J. 00 Univer	Collins sitv Blvd	Funeral L.W.Sil	Home, In	nc. ing.MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that can t only one cause on ea	used the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ò	Sencir					Onset and Death
	/Medical Examiner		resulting in death)	Due lo (o	r as a consequence of):					7 43 60
	CAMPINE	_	Sequentially list conditions,	b	r as a consequence of):					
7	bed Isit	nlne	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	\$ Du a to (o	as a consequence or,					
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of):					
8760,	ate be executed hysicien and the burial-transit	dical		d.						
9	tificate ng phys as the	fedi								
Box	death certific e attending p d for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Fetal death	3 Ectopic pregnanc	v			of delivery
	0 0	hysician/Me	in the past 12 months? 1 Yes 2 No		nt at time of death	5 Other (specify)			Mon	th Day Year
P.0	The law requires that the de Ite has been signed by the a bage 2 should be detached	Phy	9 ☐ Unknown Part II. Other significant conditi	inne contribution to de-	ath but not reculting in th	e underhine cauce a	una in Part I	23e Did to	hacco usa contri	bule to the cause of death?
ds,	signe b be c	d by	malnut	nition	at out not resulting at the	a unuanying causa gi	VOLUME CALLET.	1 [7] Y	S	3 ☐ Probably 4 ☐Unknown
of Vital Records,	w requir been si should	Completed	71:6.5	م. ١٠١ م				24a. Was a		
Rec	The lav	d E	C. 0:17	COLUTII				autop	sy pr	/ere autopsy findings available rior to completion of cause of eath?
a		e Co	25. Was case referred to medica	1	-		GC Blace of De	1 Tes	2000 200	☐ Yes 2 No
5	Physicien: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital	patient 2 ER/Outpa	tient 3 DOA Ot	hor	ath <i>(Check only oi</i> Home 5 ⊠ Resid		r (Specify)
	g Phy er thi	n:	27. Manner of Death	28a. Dale of		e of 28c. Inju			ow injury occurre	
ior	Attending I r death. ector: Alter by the funer	atlo	·	igation	, say roar, mije		Yes 2 No			
Division	. 00 -	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Place	of Injury - At home, farm g, etc. (Specify)	street, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	Hospital or 14 hours afte Funeral Dir tely filled in i		00-0-4	- Ph						
	ne Hospital or n 24 hours aft he Funeral Di pletely filled in	edical	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physician: To the t Examiner: On the bas and manne	pest of my knowledge, d sis of examination and/o er stated.	eath occurred at the t r investigation, in my	me, date and place opinion, death occi	e, and due to the our pried at the time, o	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifie			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	- 5 - 5		•	h	-	DY.	0657		6-7-	06
•	10		30. Name and address of pers	who completed cause	of death (Item 23a) (Ty			ncion M	D	
_			IZEA OU	o kunro	un Pike	Fred.	seph (Asu	.W.A., 5	500	
	Sta		31. Date filed (Month, Day, Year	9 2000	ĝistrar's Signature	Carle				
193	Regist	rar	JUN 1	2 2006	Bres De 1					

	1-	For State Registrar		-	irtment of F tificate of			Reg. No.	106	2025
Physician /Medical		Decedent's Name (First, Middle, Last) Barbara N.	Van Ho	rn			2. Date of De June 1	,2006	Year	3. Time of Death 5:45a M
Examiner uneral	4a.	Facility Name (If not institution, give s Suburban Hospi Social Security Number 6. Sex	tal 7. Age (In yrs.		4b. City, Town, of Bethe If Under 1 Year Months Days	esda	's. 8. Date of Bir	th	gome	ace (State or Foreig
mector Mount	Usu 10a	579-58-7369 14 14 15 16 16 16 16 16 16 16		Yrs. ty, Town or Lo Bethes	cation		5/16/	71942		Tida Od. Inside City Limit 1 □ Yes 2XN
Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	106	e. Street and Number 1900 Marquette			10f. Zip Code 208	1 7		10g. Citizen of	What Count	
Examiner mu		Marital Status 1 Never Married 2 Married 3 Widowed 4 Midowed 4 Midowed 1	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 Y No ff Yes, Give Year or Dates:		Vas Decedent of H I Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	14. Rac Blac Specify	ce - America ck, White, e y: B	
t, tre Medical F	E	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+) 5 +	life. I	dent's Usual Occup kind of work done DO NOT use retire Lcal Ph	a)		16b. Kind of B		ustry
atic event, To Be C	17. V	Father's Name (First, Middle, Last) Villard Nealy		,		Hattie	ame (First, Middle Mae A	llen		
ther traum	7	a. Informant's Name/Relationship (Ty, Yolanda Van Hor a. Method of Disposition	n/Daughter	3518	ng Address (Street B Esqui	and Number or I lin Ter	Rural Route Numb	er, City or Town, DWIE, Ma	ryla	.nd20716
unia di		1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Signatur 1 Funerat Service Lights 1 Signatur 1 Funerat Service Lights	emoval from State	erklaw	n Mem. I	k 6/1	1/06	Rockv	ille	, Md
eny i		la. Part1. Enter the disease, or complishock, or heart failure. List only on	las"	9	241 Col	umbia	DI FUNE Blvd.Si	lver S		
Is the burial-transit and state of the burial-transit and state of the burial-transit and state of the burial-transit and state of the burial stat	Sa if a ca Ca tha res	sulting in death) squartially list conditions, any, leading to immediate use. Enter Underlying uses (Disease or injury at initiated events sulting in death) Last	Due to (or as a consect Coronary Due to (or as a consect Due to (or as a consect	arte: quence of):	ry dise	ase				
or use a		FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of	al death 3	Ectopic pregnanc Other (specify)	у			ite of deliver	y Day Year
2 2	· Fa	nt II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause gn	ven in Part I.		obacco use cont Yes 2 □ No		e cause of death?
page 2							1 ☐ Yes	osy ormed? 2 XNo	Were autop prior to con death? 1 ☐ Yes	sy findings availab opletion of cause of 2 No
2 · 5 2		. Was case referred to medical example? 1	ospital: 1 ☐ Inpatient 2 ∑ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 🗀 Nursing	eath Check only of Home 5 Resi)
completely filled in by the funeral Medical Certification:		3 Suicide 4 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or To			
e Funerel Dietely filled i		a. Certifier (Check only one) 1X Certifying Physical Check only one) 1X Certifying Physical Cartifier 1X Certifying Physical Cartifier	sician: To the best of my known: On the basis of examination and manner stated.	owiedge, death ation and/or in	r occurred at the fivestigation, in my o	pinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, 29d. Date signe	and due to	the cause(s)
To the complet	29	> 10mirida	, mn A	terdnj	D0	055779		June '		,

			1 - For State Registrar		State of	f Marylar	nd / Depa	artment o			d Me		iene eg. No.	006	20260
	Physici		1. Decedent's Name	(First, Middle, La	st)	(1)	atts				2	Date of Deal Month JUNE 02	Day	Year	3. Time of Death 10:30 A _M
	/Medic Examin		4a. Facility Name (If r	not institution, giv	e street and nun		211	4b. City, To	wn, or Lo	cation of D	eath	OUNE OF	1	nty of Deatl	h
1	aaiiiii		SIERRA (CARE ASSIS	TED LIVIN	G		BELI	SVILI	LE			PR	INCE G	EORGES
	Funeral Director		5. Social Security Nur 164 24 245		Sex I□M 2፟ØF	7. Age (In yrs. 79	. last birthday) Yrs.	If Under 1 \ Months D		Under 24 Hours M	Min.	Date of Birth (Month, Day APRIL 06	Year)	Co	hplace (State or Foreign untry) SYLVANIA
	pu k		Usual Residence of D	ecedent 10b. County		10c C	ity, Town or Lo	ecation							10d. Inside City Limits
	Aaryle f sho	ō	MARYLAND	PRINCE C	EORGES			SVILLE							1 ☐ Yes 2 🖺 No
	28a	Director	10e. Street and Numb	per				10f. Zip Co	de			1	0g. Citizen o	of What Co	untry?
	h with	a D	13215 TAN	NEY DRIVE				20	705				US	A	
36	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow the Modell Examiner must be multined at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 🖾 No e		Was Deceden If Yes, specify	Cuban, A	anic Origin' Mexican, P Specify:	? (Specif uerto Ric	y Yes or No- can, etc.)		lack, White	
9-0	2 hou			5. Decedent's E			16a. Dece	dent's Usual C	ccupation	n n	working		16b. Kind of		
21215-0036	ithin 7	Completed	Elementary/Second	dary (0-12)	College (1	-4or 5+)	life.	DO NOT use	etired)	ng most or	working				
	Hygier Hygier other th		8	Total Middle 1 and				MACHIN			A) //	Time Adjusted to		TT	
Maryland	buld be fi Mental H arked ot atic ever	Be	17. Father's Name (F						18			First, Middle, I	машеп Бит	ame)	
Ž	should ind Men ind marke	ဥ	19a. Informant's Nam	TT GLIDEWE		<u> </u>	19b. Mailir	ng Address (S	reet and			OUDMAN Route Number	. City or Tow	vn. State. Z	ip Code)
	and 2 sealth arm 27 is		MRS. CHARLE			TER		ELBLUT D							,
re,	S 1 a		20a. Method of Dispo				Place of Dispo cemetery, crer	sition (Name	of r place)		Date	0	20c. Location	n - City or 1	Fown, State
Ē	Pages ment of I		1 ☐ Burial 2 ☑ `4 ☐ Donation 5				RT LINCO	LN CREMA	TORY	JUN	E 7,	2006	BRENTWO	OOD, MA	RYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturary in July of the traumatic event, the M. Jical <u>proce.</u>	:	21. Signature of Fund	eral Service Lice	Colvert	2		2. Name and A 800 NEW				S-RINALD E, SILVE			E YLAND 20904
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that co	aused the dea ach line.	th. Do not ent	er the mode o	f dying, s	such as car	diac or re	espiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Fi disease or condition resulting in death)	inal	_ a/	PNE	Um	oni	a						Onset and Death
	/Medical Examiner		resulting in dealing	(Due to	or as a consec	quence of):								
	ed sit	lner	Sequentially list cond if any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events	ditions, nediate ying	b. Due to (or as a consec	quence of):								
90,	cate be executed physician and the burial-transit	I Examin	that initiated events resulting in death) La	ıst	c. Due to (or as a consec	quence of):			<u> </u>					
8760,	physics the t	dlcal		•	d										
O. Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 2 9 ☐ Unknown	nopths?		irth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic pregr Other (speci						Date of deli	very Day Year
, P.O	uires that t signed by d be deta		Part II. Other signific	ant conditions	contributing to de	eath but not re	sulting in the u	nderlying caus	e given ir	n Part I.		23e. Did tob	acco use co	ontribute to	the cause of death?
rds	w requires been sign should be	ed by	Dem	entra							_	1 □ Y€	s 2 No	3 ☐ Pro	obably 4 Unknown
Records,	ne law requ has been ge 2 shouk	Completed									_	24a. Was a autops perform	V	were aut prior to c death?	topsy findings available ompletion of cause of
Vital		e Co	25. Was case referre	d to medical						Place of	Dooth (C	1 ☐ Yes 2	2 DNO		2 No
Š	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ☐ N		Hospital:	npatient 2] EFVOutpatier	nt 3 DOA	0.1			5 Reside	/	ASSISTE	ed LIVING
u of	ding Phys I. After this funeral di	J:uc	27. Manner of Death	5 Pending	28a. Date of	of Injury h, Day Year)	28b. Time or Injury	f 28c.	Injury at Work?			d. Describe ho			
Sio	Attending ir death. ector: After by the fune	catle	2 Accident	investigatio				М		2 🗆 No					
Division	or At after d Direct in by	Certification:	4 Homicide	determined	286. Place	of Injury - At h ng, etc. (Speci	nome, farm, str ify)	eet, factory, of	fice		28f	. Location (St City or Town	reet and Nur i, State)	nber or Rui	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ical Ce	(Check only 2	Certifying Pl	nysician: To the miner: On the ba	asis of examina	owledge, death	n occurred at t	he time, o	date and pl	lace, and	d due to the ca	ause(s) and i	manner as	stated. to the cause(s)
	thin 2 the the	Medical	one) 29b. Signature and ti		and manr	ner stated.			cense nu				9d. Date sign		
	€ 3 ± 8		> //	//							13 =				
	1		30. Name and address	ss of person who	completed caus	e of death (Ite	m 23a) (Type,	Print)				//	1116	. 4.	12000
			Richard	d G.	Stefa	nacc	1 Do	3250	Sta	artir	19 C	sote G	twe	odbi	, 2006 me md 21797
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	1	For State Registrar	State of Ma	aryland		artment of F			Reg. No	711115	20261
Physicia /Medic	in al	1. Decedent's Name (First, Middle, La Albun Wan	d					2. Date of Month	e oi	1, 2006	3. Time of Death 8:01 P M
Examin	er	ta. Fecility Name (If not institution, given the control of Mary	land Medic		to the same of the	4b. City, Town, o Bothin If Under 1 Year	r Location of De			:. County of Death	nplace (State or Foreign
Funeral Director		3. 000	Sex 7. Ag 1 ☑ M 2 ☐ F	e (in yrs. ia 80	ast birthday) Yrs.	Months Days		in. (Monti	5, Day, Year,) Go	BURMA
<u>D</u>	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
death with the Maryland me 23e or 28a-1 ehow rmust be notified at	tor	MARYLAND HOWARD		WOO	DBINE						1 ☐ Yes 2 ☑ No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Co	untry?
ath w		16347 FREDERICK ROAD	12. Was Decedent	Ever in 11 6	2 12	2179 Was Decedent of H		(Specify Ves		NDIA 14. Race - Ame	ncan Indian.
ie ie	by Funeral	11. Marital Status 1) Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		-	If Yes, specify Cub 1 ☐ Yes 2 🗓 No	Specify:	ierto Rican, etc	.)	Black, White	
"naturel", or	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. l	Kind of Business/	industry
filed within 72 I Hygiene. other then "nairent, in a Medic	ошо	Elementary/Secondary (0-12) 12	College (1-4or	5+)		THESIA TEC			ST .	JOSEPH'S H	OSPITAL
th Hygin	BeC	17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (First, M	iddle, Maide	n Sumame)	
should be ind Menta inarked umatic ev	70	HAROLD WARD			[ng Address (Street		ADYS DEL		or Tour State	Tin Code)
d 2 sh th and th em treum		19a. Informant's Name/Relationship		T COURT	Ì					or rown, State, 2	пр Содеу
		GLORIA LANGLEY - CON 20a. Method of Disposition 1 \(\) Burial 2 \(\) Cremation 3 4 \(\) Donation 5 \(\) Other (Spec	Removal from State	20b. Pl	ace of Dispermetery, cre	7 FREDERICK osition (Name of matory or other pla EMORIAL GAR	ce)	Date 7/2006	20c. l	ocation - City or	
permit. Pages 1 at Department of Hee Importent: If Item eny Injury on othe		21. Signature of Funeral Service Lice Muselin 1	ensee	-		2. Name and Addre L1800 NEW H					
The law requires that the death certificate be executed The law requires that the death certificate be executed XE VICTOR OF THE PROPERTY OF THE PROPERTY OF THE PAGE OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each I	hy 5 s a conseques s a conseque	uence of):		.g.				Interval Between Onset and Death
UNISION OF VITAL RECORDS, F.O. DOX Of or Attending Physician: The law requires that the death certific death. Director: After this certificate has been signed by the ettending of the tuneral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	I death 3	□Ectopic pregnand □ Other (specify) _	ey		_	23d. Date of de Month	livery Day Year
dS, T.	d by Pr	Part II. Other significant conditions	contributing to death	but not resi	ulting in the	underlying cause g	ven in Part I.	23e	37		o the cause of death? robably 4 DUnknown
The law requires the ste has been signed age 2 should be delia	Completed							24a.	Was an autopsy performed?	prior to	utopsy findings available completion of cause of s 2 \(\text{No} \)
OF VITAL TRE Physician: The I ribis certificete ha	Be	25. Was case referred to medical examiner?	Manager 18					Death (Check	only one)		
Physi Physi this o	10	1 Yes 2 No	Hospital: 1 Inpat		ER/Outpatie	AUT DOW		~~~		6 ☐Other (Spe jury occurred	ecify)
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LIVISION OF To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could no determine	200. Place Ul II	njury - At ho etc. (Specif	ome, farm, s	treet, factory, office			ation (Street or Town, Sta		ural Route Number,
Hospital 24 hours e Funeral listely filled	Medicai (Physician: To the best aminer: On the basis and manner s	of examina							
To the Tourn 2	Me	29b. Signature and title of certifier	10,	1			nse number			Date signed (Mon	
5		Mesendy	J. Vales	1	no	PI	8546	·	Ju	une 06	. 2006
		30. Name and address of person w	no completed cause of	death (Iter	n 23a) (Type	e, Print)	reet	Parl-	Hmar	m. Mar	yland zizoi
Si Regis	ate	31. Date filed (Month, Day, Year)	Regis	trar's Signa	ature	all I	1 - American 1			1	1

State of Maryland / Department of Health and Mental Hygiene 006 20262 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sylvia Agnes Woodall June 8, 2006 7:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons
Il Under 1 Year If Under 24 Hrs. 255 Swaggers Point Road Calvert 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 25F Months Days Hours 218-30-8064 72 Director Oct 21 1933 Maryland Usual Residence of Decedent the Maryland or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Solomons 1 Yes Z No Direct 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? in then "naturel", or items 23s or the Medical Examiner must be 255 Swaggers Point Road 20688 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ★o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Naval Base Elementary/Secondary (0-12) College (1-4or 5+) 12 Power Plant procurement clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked oth any lighty or other traumatic even size. Frederick Lankford 2 Amy Agnes Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Woodall- husband 255 Swaggers Point Rd. Solomons MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady Star of the Sea 13 2006 Solomons Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Process Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between (ANCER Immediate Cause (Final disease or condition resulting in death) ENDUALTNIZI Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the deeth certificate be executed physicien and s the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 certificate has been si irector, page 2 should t 1 Tes 2 200 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 200 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 C Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Momicide To the Hospital 24 hours Describing Physician: To the best of my knowledge death profund at the time. Zate and plane, and due to the cause(s) and namer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20052242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jospeh Barth MD Hospital Rd. Prince Frederick MD 20678 31. Date liled (Month, Day, Year) 32. Registra Signature State Registrar 3 3006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:05 A M JUNE 18 2006 WILLIAMS LOUISE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☑ F Days Director 212-24-6434 76 7/19/1929 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 TNo Frederick Point of Rocks MD Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4113 Rock Hall Road P.O. Box 40 21777 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mentel Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Scally Robert M. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre QDC4. Robert H. Hartman Jr. 8106 Cambridge Drive Frederick, MD 21704 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Paul Cemetery 6/22/2006 Point of Rocks, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee Man M01176 106 East Church Street Frederick, MD 21701 Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cate MICLORDIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Physician/Medicai ettending physi 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medicai Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 🗍 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anes uning 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 27 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 14, 2006 **Physician** 5:00 PM Mary Madaline Winner /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lonaconing Allegany 57 Jackson Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Days Months Yrs. Director 213-44-1770 63 November 29, 1942 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23a or 28a-f shor the Medical Examiner must be notified at 1 Yes 2 □ No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21539 **USA** 57 Jackson Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☒ Divorced Year or Dates: White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher School System 12 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Madaline Klipstein William Alexander Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 4131 Backwoods Road, Westminster, Maryland, 21158 Andrew Winner - Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 I Cremation 3 □ Removal from State June 17, 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** Cumberland, Maryland 2006 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main Street, Lonaconing, MD 21539 at1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, s lock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ver circhosis Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician end I for use es the burlel-trensit or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assort Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 Tes 1 □ Yes 2 3 46 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 7No Other: 4 → Norsing Home 5 □ Residence 6 □ Other (Specify) Medicai Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 | Natural 5 ☐ Pending investigation efter death.

Director: Aft
d in by the fur 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours en To the Funerel Discompletely filled in 29a. Certifier (Check only one) The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month Day Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 4 Broadway, Frostburg, Maryland Jesus

State

31. Date filed (Month, Day, Year)

JUN 1 6 2006

32. Registrar's Signature

			State State RegistraMPND#10eperINF6/20/	e of Marylar		rtment of H			giene 200	6 20265
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici		Prem Deben AKA Joh	ın Carter	Willia	no Ir		June 7	Day Year 7 2006	12:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give street ar		WIIIIA	4b. City, Town, or	Location of Dea		4c. County of De	
	Funeral Director		Holy Cross Hospital 5. Social Security Number 6. Sex 152 M 25		. last birthday) Yrs.	Silver If Under 1 Year Months Days	Spring If Under 24 Hr. Hours Min		v, Year)	omery irthplace (State or Foreign country) inessee
	2		Usual Residence of Decedent							
	how	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Montgomery		Silve	Spring				1 ☐ Yes 2√2 No
	or 28	Director	10e Street and Number 8 6 0 0			10f. Zip Code			10g. Citizen of What (Country?
	23a		8200 16th Street #10	12		20	910		USA	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23s or 28s-f ehow other traumatic event, Ifm Madical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1 If Ye	Decedent Ever in Used Forces? Yes 2 \(\) ZNo es, Give r or Dates:	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2131 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Specify:	
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g	al Hy	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>a</u>	uld b Menta urked utic e	10	John Carter Williams,	_Sr.			Mosea.	le Louise	Molten	
a	sho and l		19a. Informant's Name/Relationship (Type, Prin	t)	19b. Mailin	g Address (Street	and Number or F	ural Route Numbe	r, City or Town, State,	Zip Code)
	and 2 alth 27 r		Mary J. Goyette Dau	ghter		Haywood	Drive :	Silver Sp	ring MD 2	20902
Baltimore,	of He of He item		20a. Method of Disposition		Place of Dispos	atory or other plac		Date	20c. Location - City of	
Ĕ	permit. Pages 1 Department of H importent: If ite eny injury or ott		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	rrom State Me	tropoli	tan Cremator	1	10.2006	Alexandria	Virginia
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Ö	20 E 2 G		> Kakard I Acles		50	O Univer	dety R1	d W Si	. Home, Inc .lver Sprin	. MD 20001
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	led sit	Examiner	cause (Disease or injury	20 10 (01 40 4 0011301	quarios 01).					
	and and	xar	that initiated events resulting in death) Last	ue to (or as a conse	quence of):					
8760,	icate be executed physician and s the burial-transit	aiE			,					
387	icate phys s the	dicai	d							
Vital Records, P.O. Box (The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	s, outcome of pregn Live birth 2 ☐ Fet Pregnant at time of d Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
۵.	that the	P.	Part II. Other significant conditions contributing	to death but not re	sulting in the un	derlying cause give	en in Part I	23e. Did to	bacco use contribute	to the cause of death?
ords,	w requires t been signe should be	ted by								Probably 4 Unknown
Rec	The law i ate has be bage 2 sh	Completed						24a. Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of
Ħ	tan: rtifica	Be C	25. Was case referred to medical examiner?			***************************************	26. Place of De	ath Check only or	10,	
>	nysic direc	To	1 ☐ Yes 25 No Hospital:	1X Inpatient 2	ER/Outpatient	3□ DOA Othe	er: 4 Nursing	Home 5 ☐ Resid	ence 6 □Other (Sp	ecify)
Division of	Attending Physicien: The Ir death. c death. ector: After this certificate hay the funeral director, page	ation:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y			ow injury occurred	
<u>Š</u>	To the Hospital or Attentwithin 24 hours after deall To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)	et, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	the Hospital or hin 24 hours after the Funeral Diru upletely filled in t	edicai	29a. Certifier 1 Certifying Physician: 1 Check only one) 2 Medical Examiner: On and	o the best of my knother basis of examination of the basis of examination of the basis of the ba	owledge, death ation and/or inv	occurred at the time estigation, in my op	ne, date and plac pinion, death occ	e, and due to the durred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	4	29d. Date signed (Mor	th, Day, Year)
}	10		AJ IN	P. KURU	Will, 1	10 D 4	0187		June 7, 20	06
	("		30. Name and address of person who completed							
			Ajit P. Kuruvilla, M.D.	11125	Rockvil	le Pike	#208 Ro	ckville,	Maryland	20852
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 2 2006	32. Registrar's Sign	ature	the second				

		-	For State Registrar	State of Maryland		artment of Heartificate of De			giene 0	06	20	266
	Obvoisir		1. Decedent's Name (First, Middle, L					2. Date of Dea Month	th Day	Year	3. Time o	
	Physicia /Medic	al -	KATHERINE	HELENE	WARF			JUNE 9			8:15	/J, M
	Examin	er	4a. Facility Name (If not institution, gr BROADMORE ASSIS			4b. City, Town, or Loc HAGERSTON			4c. County			
	Funeral			Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	1		olace (State	or Foreign
	Director		213 30 4713	1 M 2 M F 74	Yrs.	Months Days H	lours Min.	(Month, Day DEC . 29		MARY		
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c. City	r, Town or Lo	ocation				1	0d. Inside C	City Limits
	Manyla f sho	ō	MD. WASHING	GTON HAC	GERSTO	WN					1,⊠Yes	2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	
	th with		201 MEADOW DRIVE			21740			UNITED	STAT	ES	
	after death with the Marylan or items 23a or 28a-f show into set notalities at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White,	an Indian, etc.	
5	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		1⊡Yes 2,⊠No S	Specify:		Specify	· WHI	TE	
9200-612	filed within 72 hours after death with the Maryland Hyglene. ther than "netural", or Items 23a or 28a-f show ther than "netural", or Items 23a or 28a-f show ont, the Medical Erami act must be notified at	ted	15. Decedent's (Specify only highest g		16a. Dece	dent's Usual Occupation kind of work done durin	n na most of workin	10	16b. Kind of Bu	isiness/Inc	dustry	
2	ithin 7 nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ng most or works	<i>'</i> 9				
2	e filed w Hygier other th	Cor	17. Father's Name (First, Middle, Las	0	ADMI	NISTRATOR	. Mother's Name	(First, Middle,	SECURIT Maiden Sumam		MPANY	
/lanc	m - 0 %	To Be	CLIFFORD THEODO				HELEN			MAKEI	R	
Baltimore, Maryland 21	nd 2 sho lith and 27 is ma r traums		19a. Informant's Name/Relationship ELLEN C. BACHTELI			ng Address (Street and MEADOW DRI\			-	State, Zip 1740	Code)	
ē,	of Healitem		20a. Method of Disposition	20b. P	lace of Dispo emetery, crea	osition (Name of matory or other place)	D	ate	20c. Location -	City or To	wn, State	
Ē	Pages ment of l ant: if its ury or o		1 M Burial 2 □ Cremation 3 • 4 □ Donation 5 □ Other (Spec	Hemoval from State		lle Cemeter	ry 6/14/	06	Laytons	ville	e, Md	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic engage.		21. Signature of Funeral Service Lice	Barler		Name and Address of MURIEL H. E				200	882	
	×		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death	n. Do not en	P.O. BOX 50 ter the mode of dying, s	such as cardiac o	r respiratory ar	rest,	<u></u>	Approxima Interval Be	ite etween
	Physician		Immediate Cause (Final disease or condition	SEVERE PA	exides	d's Nueg	re			1.	Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	No.						
l.	LXammer	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):							
	uted I	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	an and rial-tre	Еха	resulting in death) Last	Due to (or as a consequ	uence of):							
8760	cate be executed obysician and the burial-transit	lical		d								
Ó	ertific ding p	Mec	IF FEMALE:	23c. If yes, outcome of pregna	IDCV				004 0			
Вох	that the death certific ed by the attending p detached for use as	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	I death 3	☐Ectopic pregnancy ☐ Other (specify)			Mo	te of delive nth	•	Year
P.O.	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown								
	Se US	by	Part II. Other significant conditions PAOCRECTIVE	contributing to death but not resu	ulting in the t	underlying cause given i	in Part I.	23e. Did to	bacco use control		he cause of bably 4	
Š	w requir been si should	Completed	17)06/06/11/10	20191111				24a. Was	4228	Were autr	psy findings	s available
Rec	he taw s has ige 2 :	mp						autop	rmed2	prior to co death?	mpletion of	cause of
ta	en: T tificate tor, pa	a	25. Was case referred to medical			26	6. Place of Death			1 🗌 Yes	2 No	
<u> </u>	nysici iis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	EP/Outpatie	nt 3□ DOA Other:	4 Nursing Hor	me 5 ☐ Resid	lence 6 th	er (Specif	ASS IS	
0	ing Pt		27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		28d. Describe h	now injury occurr	ed	FACIL	
sio	uttendi death. ctor: A y the fu	icat	2 Accident investigal 3 Suicide 6 Could no	t he	ome form et		s 2 □No	28f Location /5	Street and Numb	er or Rus	al Route Nu	mher
Division of Vital Records,	after after Direction by	ertification:	4 Homicide determin	28e. Place of Injury - At he building, etc. (Specify	y)	reet, radory, office		City or Tow	vn, State)	or or Fiore	17 110010 1 101	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) (Check only one)	Physician: To the best of my kno caminer: On the basis of examina and manner stated.	owledge, dea ition and/or i	th occurred at the time, nvestigation, in my opini	date and place, a ion, death occurre	and due to the ded at the time,	cause(s) and ma	nner as s and due to	tated.	(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	. / /		29c. License no	umber		29d. Date signe		Day, Year)	
)	7		Park Fo	+ Brother		238	892		6/101	06		
	1		~	no completed cause of death (Item		1	E 130	<i>Q</i> \	HAGE	RITE	WN,	
			PATOA FOX (31. Date filed (Month, Day, Year)	32. Me gistrar's Signa	//// O	1001 CAL	GMAUS	, 100	MD	2179	42	
	Regist	ate rar	JUN 12	2006 June 1	15. P	DON'TE!						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Katherine Randolph White

		- For State	Cer	tificate of			eg. No 201	76 2021
Physicia ledical Exami	n/	Decedent's Name (First, Middle,Last)	3 - 3 - 1		• • -	2. Date of Dea Month	Day Year	3. Time of Death 1601 hrs
leuicai Examii		Katherine Ra 4a. Facility Name (if not institution, give stree	ndo1ph et and number)		nite City, Town, or Location	June 6, 20 n of Death	4c. County of Death	1007 1113
		3353 Style Avenue			Laurel		Anne Arundel	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year If Un Months Days Hou	ırs Min	rth(MM/DD/YYYY) 9. Birt Foreig	n
Director			2 <u>₹</u> XF 32	Yrs.		Feb.	15, 1974 Co.	untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locatio	n			10d Inside City Limits
ž ,	٦	MD Anne Arun	ndel La	urel				1 Yes 2 X No
Maryla 28a-f d at or	Director	10e. Street and Number			10f. Zip Code	1	l0g, Citizen of What Cour	ntry?
th the 23a or notifie		3353 Style Avenue			20724		USA	
ath wi	Funeral		Was Decedent Ever in U. Armed Forces?		Decedent of Hispanic C s, specify Cuban, Mexic	origin? (Specify Yes or No an, Puerto Rican, etc.)	0- 14. Race - Ameri White, etc.	can Indian, Black,
fter de		3 Widowed 4 Divorced If Yes	Yes 2X No	1 .	es 2 X No speci	fy	Specify: W	nite
nours a	od be	15. Decedent's Education (Specify only hig			Usual Occupation (Givent of working life, DO NO		16b. Kind of Business/li	ndustry
36 in 72 h han "r	mpleted	Elementary/Secondary (0-12)	ollege (1-4 or 5+)		-		Amahaalaa	_
d with	S	17. Father's Name (First, Middle, Last)	4	Archeo1		ner's Name (First, Middle,	Archeology Maiden Surname)	7
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica	_	Anthony Randolph 19a. Informani's Name/Relationship (Type, P			Re	becca Young		
	2	19a. Informant's Name/Relationship (Type, F William Brian White		_	,	umber or Rural Route Nu ie, Laurel,	mber, City or Town, State	, Zip Code)
and 2 sho lealth and trem 27 is traumati		20a. Method of Disposition	20b F	Place of Disposit	on (Name of cemetery,	Date	20c. Location - City or	Town, State
E & E E E		1 Burial 2 XXCremation 3 Re 4 Donation 5 Other Specify:	silloval irolli state	crematory or other	• '	6-10-2006	Baltimore	MD
Baltimo permit. Page Department of Important: injury or oth	1	21. Signature of Funeral Service Licensee	1	22. Na	me and Address of Fac	ility		, 110
		Jat J WII	/		2 Ridgely A		polis, MD 2.	
Physician /Medical		23a. Part I. Enter be disease, or complication failure. List only one cause on each line.	e,		e mode or dying, such a	s cardiac or respiratory ar	rest, snock, or neart	Approximate Interval Between Onset and Death
Examiner			nyxia and Blunt For o (or as a consequence o					
ممر	<u>.</u>	Sequentially list conditions, b.	o (or as a consequence o	vf):				
	nine	cause Enter Underlying Cause (Disease or injury that initiated						
ted I Insit	Examin	events resulting in death) Last Due to	o (or as a consequence o	of):				
760, crate be executed physician and the burial - transit	Medical		ENDED					
760, icate be gaphysicia the buria		IF FEMALE: 23 23b. Was decedent pregnant in the	c. If yes, outcome of preg				23d. Date of delivery	
68 certif nding se as	cian	past 12 months?	Live birth Pregnant at time of de	ath	er (Specify)	ppic pregnancy	Month E	Day Year
Box e death c the atten	Physi	1 Yes 2 No 9 V Unknown 9	Unknown					
, P.O.	by P	Part II. Other significant conditions conti	ributing to death but not r	esulting in the ur	derlying cause given in		obacco use contribute to es 2 V No 3 Prob	
ords, l	eted						an 24b. Were au	topsy findings available
COF c law r e has b ge 2 sh	Completed			* .*			ormed? death?	completion of cause of
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b		25. Was case referred to medical			26 Place of Dea	th (Check only one)	2 No 1 ✓ Y∈	es 2 No
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient 2	ER/Outpatient	3 DOA Other	Nursing Home 5	Residence 6 Other	. Scene
n of ding Ph	on: T	1 Notural	Rea. Date of Injury FOUND: POUND:	28b. Time of In FOUND:	ury 28c. Injury at W	 Subject ass 	how injury occurred saulted	
Division tal or Attendi rs after death. al Director: /	icati	2 Accident Investigation	Jun 6, 2006 28e. Place of Injury - At h	1558 hrs			Street and Number or Ru	ral Route Number City
Divipital or ours afte eral Dir	Certification:	Suicide Could not be	(Specify) Single Far		,, ,	or Town,		
		29a. Certifier 1 Certifying Physician: 1					ise(s) and manner as star	
To the Hos within 24 h To the Fun	Medical		he basis of examination a manner stated	and/or investigati	29c. License numb		and place, and due to the	
	2	29b. Signature and title of certifier	BODAIN		O.C.M.E.		June 7, 2006	nur, Day, 1981)
		30. Name and address of person who comp	leted cause of death (Item	n 23a)				
		Carol Allan, MD Assistant M	ledical Examiner		treet, Baltimore, N	/ID 21201		
S Regis	tate	31. Date filed (<i>Month, Day</i> , Year) JUN 0 9 2006	37 Registrar's Signat	ure	£ 0			
DHMH 17 Rev 1/2		0011 0 0 2000		URIGINAL				

	. PUI	•	nent of Health a		21111	6 20260
	1 - State Registrar Amend #5 Per FH G857 7	/10/06/9ff ^{///}	cate of Death	2. Date of Dea	th	3. Time of Death
Physician		TON, SR		JUNE	Day Year 11 200	, a.a. M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)		. City, Town, or Location of		4c. County of De	
	UPPER CHESAPEAKE MEDICAL CENT 5.935-2-091-A-036 6. Sex 7. Age (In		BEL AIR Under 1 Year If Under 2	4 Hrs. 8. Date of Birth		RFORD
Funeral Director	5.212-28-4818 6. Sex 1. 7. Age (In 1. 1. 2. 1. 1. 2. 1. 1. 2. 1. 1. 2. 1. 2. 1. 1. 2. 1. 1. 2. 1. 1. 2. 1. 1. 2. 1. 1. 2. 1. 1. 1. 2. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		onths Days Hours	Min. (Month, Oay Sept 25		irthplace (State or Foreign Country) ryland
p s	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Location	on .			10d. Inside City Limits
n the Maryland r 28s-f ahow incillied at	Maryland Harford	. ony, town or cooding	Bel Air			1 XYes 2 □ No
vith the Ma be nedfles	10e. Street and Number	1	Of. Zip Code	1	log. Citizen of What (Country?
death with the Maryland me 23e or 28e-f ehow frame by notified at neral Director	2403 Hannah Road		2101		USA	
Suffer death volume 23st	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 1 Never 2 No	in U.S. 13. Was	Decedent of Hispanic Orig s, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
030 urs a	3 Widowed 4 Divorced If Yes, Give Year or Dates:	10	Yes 2 No Specify:		Specify: P	lack
21215-0 21215-0 99jene. Syliene. It, the Medical It, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occupation of work done during most NOT use retired)	of working	16b. Kind of Busines	s/Industry
d 2121 d 2121 filed within the than ant, tream	Elementary/Secondary (0-12) College (1-4or 5+)		retaker		Cemet	tery
7 4 8 5 5 7 10	17. Father's Name (First, Middle, Last)		18. Mother	's Name (First, Middle,	Maiden Sumame)	
laryland	Herbert Columbus Walton			na Peacco		
Maryland nd 2 should be fit and Mantal Hy 27 is marked oth ir traumatic even	19a. Informant's Name/Relationship (Type, Print) Mary Jane Walton / wife		annah Road			
DOC, Modern Mages 1 and 2 and 27 in team 27 or other true	20a. Method of Disposition	Ob. Place of Disposition Cemetery, cremato	n (Name of	Date Date	20c. Location : City	
Pages ment of ant: if it	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		ove AME Cem.	6/17/06	Street,	Maryland
Baltimore, Ma Baltimore, Ma permit Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra	21. Signature of Funeral Service Licensee		me and Address of Facility Lisa Scott F		. P.A.	
9 - 403.44	23a, Part1. Enter the disease, or complications that caused the	death. Do not enter th	552 Lewis St	reet, Havre	de Grace,	MD 21078
Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 =	100 monia			Interval Between Onset and Death
/Medical	disease or condition resulting in death) a		100 WOWIA			D HOURS
Examiner	Sequentially list conditions, b. SCP51S	Commission on				2 Hoyrs
ted nsit	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events	rosmola	or chile			2 Hours
8760, cate be executed physician and the burial-transit dical Examin	resulting in death) Last C. Due to (grat a con	nsequence of):	210015			
18760 cate be e physician the buria	d					-
	IF FEMALE: 23c. If yes, outcome of pr	regnancy			23d. Date of d	lalivas
TAY MODDOD IN IRECORDS, P.O. Box 6 The law requires that the death certiful the has been signed by the attending bage 2 should be detached for use as completed by Physician/Me	23b. Was decedent pregnant 1 Live birth 2 1 In the past 12 months? 4 Pregnant at time	Fetal death 3 Ect	opic pregnancy ner (s <i>pecify</i>)		Month Month	Day Year
o. O. O. o. o. o. o. o. o. o. o. o. o. o. o. o.	9 □ Unknown					
	Part II. Other significant conditions contributing to death but no	t resulting in the under	tying cause given in Part I.	23e. Did to	1	to the cause of death? Probably 4 Unknown
Vital Records, sician: The law requires t certificate has been signe rector, page 2 should be o		· · · · · · · · · · · · · · · · · · ·		24a. Was a	- 1	autopsy findings available
Vital Rec Vital Rec retain: The law s certificate has b firector, page 2 s				autops perfor	med2 prior to death	completion of cause of
	25. Was case referred to medical		26. Place	1 ☐ Yes of Death (Check only or		es 2 No
of Vi hysicia his cer al direct	examiner? 1 Yes Hospital: 1 Inpatient	-	3□ DOA Other: 4□ Nur	sing Home 5 Resid		pecify)
Sion of Sion of Sion of Sion of Sion of Sion of Sion of Sion of Sion Sion Sion Sion Sion Sion Sion Sion	27. Manner of Death Natural 5 ☐ Pending 28a. Date of Injury		28c. Injury at Work? M 1 □ Yes 2 □ N		ow injury occurred	
Division of Vital Division of Vital after death. Director: After this certification. In by the funeral director. ertification: To Be G	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, street.		28f. Location (S	treet and Number or	Rural Route Number,
S Page 1	4 Hornicide Duilding, etc. (5)			City or Tow		
Hosp 24 hou Fune fely fi	29a. Certifier (Check ority 2 Medical Examiner: On the basis of examin	y knowledge, death occ mination and/or investi	curred at the time, date and igation, in my opinion, deat	d place, and due to the c h occurred at the time, o	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
Within 2 within 2 complete	one) and marrier stated. 29b. Signature and atte of certifier		29c. License number	1	29d. Date signed (Mo	nth, Day, Year)
F3+0	> Swarm mon	w	H4106	9	June 12.	2006
	30. Name and address of person who completed cause of death	(Item 23a) (Type, Prin	1) (1)	John E	4	21015
6 State	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature A	ess Center	Way E	ugewood	C(01>
State Registrar	DR STANDEY I MAN 13 31. Date filed (Month, Day, Year) 32. Registrars S JUN 13 2006	un to by	CON	•		

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 20269 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 2006 13 7:00 P.M June Zinn Mann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Asbury Methodist Village Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 WV 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**□ F Months Yrs. 10 1921 85 Jan. Director 299-34-4571 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MDMontgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō United States 20877 or Itams 23a 301 Russell Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: ģ White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) then Elementary/Secondary (0-12) Grants Management Clerk National Inst. Health permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If item 271s marked other any injury or other traumest. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cline Christie James Forest Mann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5514 Oakmont Ave., Bethesda, MD 20817-3528 Mr. Roger D. Zinn, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t ☐ Burial 2 XCremation 3 ☐ Removal from State Cumberland Crematory 6/14/06 4 □ Donation 5 □ Other (Specify) Cumberland, MD 22. Name and Address of Facility Burdock-Durst Funeral Home 21. Signature of Funeral Service Licensee Katherine 21 N. Second St., Oakland, MD 21550 Sucinco 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) After this funeral of 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending investigation after death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NR Sheet brisch banker 204115 Vune 13,2006 201 RUSSELL AVENUE CATTHERSBURG, MA 20847 30. Name and address of person who completed cause of death (Item 234 (Type, Print) 14, ROBERT BIRSCHBARHU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUN 15 Registrar

			- State Amend Items	State of Maryland 24a, 25, 26, 27	d / Depa 29 c 3	rtment of He Der Dr. tificate of L	ealth and M C856,06/ leath	28/06df	jene2 () (eg. No.	16 2	0270
	Division		1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month	th	3. Ti	me of Death
	Physici /Medic	_	Terrence Brooks					May 24,		9:	30 a ^M
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	r 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?	
	th wit	a D	313 Mill Street			12601			USA		
	72 hours after death with the Maryland natural', or Heme 23a or 28a-f ehow dical Examinar must be multikal at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No		Was Decedent of His f Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indi White, etc.	an,
5	ral', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	black	
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N O	e fited within al Hygiene. I other then '	Be Co	17. Father's Name (First, Middle, Last)	one	Const		18. Mother's Name	(First, Middle,	Maiden Sumame)	unk
Maryland	should be nd Mental marked c	To B	Bernard Brooks								unk
<u>a</u>	2 shot and h is ma		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	l Route Number	; City or Town, S	tate, Zip Code)	
	1 and 2 Health tem 27		Challise Brooks/wi			Box 754 S				it. a. Tour Ct	nt o
Baltimore,	permit. Pages 1 an Department of Heali Importent: If Item 2 any injury or other <u>once.</u>	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 🖾 Other (Specify)	emoval mom state		sition (Name of natory or other place			20c. Location - C		
Ball	permit Depart Import any inj		21. Signatur Funeral Service License Renald S. V	Director	- St - St	Name and Address tate Anato altimore,	s of Facility Dmy Board MD 21201	655 W.	Baltimo	re Stre	et
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۵.	law requires that the deas been signed by the.	þ	Part II. Other significant conditions con	stributing to death but not res	ulting in the u	nderlying cause give	n in Part I.		bacco use contrit es 2 □ No 3		
Records,	The law requir ste has been si page 2 should	Completed						24a. Was a autops	sy pr	ere autopsy find or to completion ath?	dings available n of cause of
Vital		ပိ	25. Was case referred to medical				26. Place of Death	Yes Yes]Yes 2□N	
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on of	ling After fune		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		ow injury occurre		
Division	or Attendifter deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)			28f. Location (S City or Town	treet and Number n, State)	or Rural Route	Number,
	Hospite 14 hours Funere tely fille	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							use(s)
	within 2 To the comple	Me	29b. Signature and title of certifier			29c. License		2	9d. Date signed	(Month, Day, Yo	ear)
1) Ohn	MD MD		D 03	4 61 - D609	999	6/6/	06.	
			30. Name and address of person who co				n, D.C. 2	20010			
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		1 - For State Registrar	State of Maryla		artmen rtificat				F	Reg. No.	006	
Physicia	an	Decedent's Name (First, Middle, Last)							. Date of Dea Month	Day	Year	3. Time of Death
/Medic		Alice M. Baity				-			June 2,	-	unty of Death	6:10 A M
Examin	er	4a. Facility Name (If not institution, give s					Location of	Death			derick	
		Northhampton Manor 5. Social Security Number 6. Sex		s. last birthday)		leric	K If Under 2	24 Hrs 8	I. Date of Birt	h	9. Birth	place (State or Foreign
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how	_	10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits 1∑Yes 2☐No
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itema 23a or 28a-f show aurnatic event, the Medical Examinar must be collified at	Director	Maryland Frederic	c F	rederic						10- Oiti	of What Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygiens. Department of Health and Martal Hygiens "ratural", or Itema 23a or 28e-4 ehov Important: If Item 27 is marked other then "ratural", or Itema 23a or 28e-4 ehov Important: If Item 27 is marked other then "half all Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at ODGE.	P	10e. Street and Number			10f. Zir							ridy:
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ter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		If Yes, spe	city Cuba	n, Mexican	, Puerto Ri	can, etc.)		Black, White	etc.
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tygier th		11. Father's Name (First, Middle, Last)		Medic	ear Se	cret		r's Name /	First, Middle,		ical_	
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P the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		treet, facto	ry, office		21	Bf. Location (City or To	Street and N wn, State)	lumber or Ru	ral Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier 1 Cartifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my nar: On the basis of exan and manner stated.	knowledge, dea nination and/or i	ath occurred investigation	d at the time n, in my c	ne, date an pinion, dea	nd place, ar ith occurre	nd due to the d at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29		e number	,			igned (Month	, Day, Year)
		170 m		wo		D2	193	4		61	2/06	
4		30. Name and address of person who co		_								
-1		A.DINELSON			THOW	45	MOON	199	0× ,	FR	2 dec	ce 2170
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	Jan Ji							

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2006 June 21, 2:50 P M **Physician** Elizabeth Barrett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours **Funeral** Months Days 1 🗆 M Jan 16, 1928 Virginia Director 578 34 2505 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Prince George's Fort Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 20744 2838 Lindes Farn Terrace United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if from 27 is marked other than "nature!" any liqury or other traumatic event Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 ☐ No Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 ₩No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Retired) Tailor 6th Weaver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nathaniel Williams Estelle Twyman ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gail A. Burress (Daughter) 5205 Morris Ave, Suitland, MD 20746 20b. Place of Disposition (Name of cometery, crematory or other place) June 26, 2006 20c. Location - City or Town, State 20a. Method of Disposition
1 Maurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Lice 200153 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Obstructive Jaundice Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Chalangiocarcincoma Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes → ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de δ Division of Vital Records, Breast Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 🖫 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 V tto 1 ☐ Yes 2 🕅 🕅 0 certificate 25. Was case referred to medical examiner? 26. Pface of Death | Check only one) Hospital: 1 y Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2/2/No his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation after death.
I Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funaral C completely filled i 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D0055522 June 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest, Glen Road, Silver Spring, Md 20910 M.D Robert H. Gerard,

Registrar DHMH 17 Rev 1/2001 2006

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 20273

					Cei	rtificate	of	Death			Reg. No.		L O L 1 C
	u-	1. Decedent's Name (First, Midd	ile, Lest)							2. Date of De		Year	3. Time of Death
	Physician	William A	. Baiardo							June	26, 2006)	10:40 A.M
	/Medical Examiner	4a Facility Name (If not institution		mber)			T.	4b. City, To	wn, or Lo	ocation of Deat		y of Death	
-/-	Examine	Pineview N	areine Hor	200				Clint	on		Princ	ce Geo	orge's
_		5. Social Security Number	6. Sex	7. Age (In yrs. I	est birthday)	If Under 1				8. Date of Bi			
	Funeral	578 10 4337	1⊟-M 2□ F	92	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Do April	y, Yeer) 13 10	Cour.	place (State or Foreign htry). VYOT!
	Director	Usual Residence of Decedent	AA	92				1		VOLIT	10, 17.	4 ItC	W TOLK
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	filed within 72 hours aftar death with the Maryland Hygiene. ther than "natural", or items 23a or 28s-f show ant, the Medical Examiner must be notified at a Completed by Funeral Director	4501 henders											
	ep in de	11. Marital Status	Armod Er		S. 13.	Was Decede If Yes, specif	nt of H	lispanic Or an, Mexica	igin? (Sp n, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - American Indian Black, White, etc.			
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b	be file tel Hy d oth event	17. Father's Name (First, Middle	, Lest)					18. Moth	er's Nam	e (First, Middle	, Maiden Suma	me)	
<u>a</u>	ould be 1 Mentel 1 Merked of marked of	Frank Bai	iardo					Rit	ta Ga	itti			
Maryland	s marked aumetic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Nu							al Route Numb	mber, City or Town, State, Zip Code)			
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a,	-755	20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name	of .	. Jur	ne 20	, De2006	20c. Location	- City or To	own, State
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Baltimore,	pemit. Pa Departmen Important: any injury once.	21. Signature of Funeral Service	Licensee		22						l Home,		
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		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	aused the death	. Do not ent	er the mode	of dyir	ng, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	SHOCK, OF FRAIL FAILURE. LIS	or only one cause on	sacri iirie.								1	Onset and Death
, and	/Medical	Immediate Cause (Final	/		- 4	1		d		4		1	170-
100	Examiner	disease or condition resulting in death)	a	will	VZ,	17	\widehat{A}	a	201	aze			1 Doc
	ē	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									I i	7 2 1.	
	nsit nsit		b	Hul	ψ_{-}	1/15	×	ille	m				1 Day
_	certificeta be executed nding physician and usa as the bunal-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-	Due to (or	as a consec	uer/ce of).							Timb
68760,	be e cian ician buris	cause. Enter Underlying Cause (Disease or injury	0. /4	ne I	DA	N							218
87	certificeta be nding physicia usa as the bu	that initiated events resulting in death) Last Due to (or as a consequence of):									U		
9 xo	ing pa as		d									į	
Bo	tand or us		<u> </u>										
-	The lew requiras that the death ate has been signed by the atter page 2 should be detached for Completed by Physicial	Part II. Other aignificant conditi	lona contributing to d	eath but not resu	Ilting in the u	nderlying cau	ise giv	en in Part	l.	23b. Did	tobecco use co	ontribute to	the cause of death?
P.O.	by the									1 🗆	Yes 2 No	3 Prol	bably 4 🗆 Unknown
-ć	as the igned be de be de												
of Vital Records,	v require been signatured the										an autopsy omed?	24b. We	ere autopsy findings ailable prior to
ပ္ပ	sho sho									pen	Jiiil o u?	CO	mpletion of cause death?
Re	The lew require sate has been signate has been signated and Completed									W. W.	No.]Yes 2□No
ā	icate										Yes 212No	1	Tes ZLINO
₹	Physician: The this cartificate ral director, page: To Be Co	25. Was case referred to medical examiner?	Hospital:				Oth	/		h (Check only	1221	-	
£	Physic this caral direction To To	1 ☐ Yes 2 ☑ No	10		ER/Outpatier			4 E N			idence 6 DOt		ý)
_	ftar I there in on:	27. Man ver of Death 1 ☑ Natural 5 ☐ Pendi	ing 28a. Date	of Injury th, Dey Year)	28b. Time of Injury		. Injur Wor			28d. Describe	how injury occu	rred	
<u>S</u>	Attending in death. ector: Attaction iffication	2 Accident invest	tigation			М	1 🗆	Yes 2□	No				
Division	tal or Attending P rs efter death. el Director: After t led in by the funers Certification:	3 Suicide 6 Could 4 Homicide deter	mined 286. Place	of Injury - At ho	me, farm, str	eet, factory,	office				Street and Num wn, State)	ber or Rure	el Route Number,
	s eft s eft	/			,								
		29a. Certifier 12 Certifyi	ng Physician: To the	best of my know	viedge, death	occurred at	the tir	me, date ar	d place,	and due to the	cause(s) and m	anner as s	tated.
	ne Hospi n 24 hou ne Funer pletely fill edical	(Check only 2 Medica one)	Examiner: On the b and man	asis of examinati ner stated.	ion and/or in	vestigation, in	ı my c	pinion, dea	un occur	ed at the time,	uate and place	, and due to	o trie cause(s)
	Vithin To the Somp	29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer)											
	- > - 0	D-24535 06.2706									06		
	19	20 Name and address of	y who completed a	no of donth /lta-	22e) (T	Print\					00,		
	0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lakeri N. Berwa, M.D. 7700 Branch Ave #C101, Clinton, MD 20735											
de la		31. Date filed (Month, Day, Year	7) 32 5	distrar's Sinnat	ure								
	State	.IIIN 9	8 2006	Mistrar's Signat	1. 1	mode							
	Registrar	0011 2	1	a south the said	-	-			_				

06-04393 Lisa Balcer

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		For State		Certifica	ate of D	eath		,,,	Reg. N	lo Z		6 202								
Physician/ Medical Examine	1	Decedent's Name (First, Middle Lisa M. Bal						2. Date o Month June :	f Death Day 23, 2006	y Year		3. Time of Death 0618 hrs								
	4	a. Facility Name (if not institution John Hopkins Bayview				City, Town, or Baltimore	Location of	Death		4c. County of	Death									
Funeral Director	- 1	. Social Security Number 2 1 7 - 6 2 - 2 9 3 4		yrs. last birtl	-	f Under 1 Yea Months Day	$\overline{}$	Min.	,		Foreign	nplace (State or n intry) M.D.								
nd show any see.	1	Usual Residence of Decedent Oa. State 10b. County M D		City, Town		City						10d. Inside City Limits 1 Yes 2 No								
the Maryland a or 28a-f show tiffed at once.		Oe. Street and Number 719 Oldham St			1	Of. Zip Code				Citizen of Wha	it Coun	try?								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Filmeral Director		1. Marital Status 1. Never Married 2. Mar 3. Widowed 4. Divo	12. Was Decedent Eve Armed Forces? 1 Yes 2 X		If Yes,		n, Mexican, I	n? (Specify Yes Puerto Rican, etc		14 Race - White, Specify: T	etc.	an Indian, Black,								
5-0036 ed within 72 hours aft lygiene. lygiene. he Medical Examine	naiaid	15. Decedent's Education (Special Elementary/Secondary (0-12)	cify only highest grade complet College (1-4 or 5+)		during most	of working life	. DO NOT u	ind of work done ise retired)		o. Kind of Bus										
215-0036 be filed within 72 mtal Hygiene. rked other than ' ent, the Medical		7. Father's Name (First, Middle, Robert Krebs	Last)		56	creta	18.Mother's	Name (First, Min	ddle, Maid		LST	ration								
nore, MD 21215-C ages I and 2 should be filed v If file and Mental High it: If file and Mental High other traumatic event, the To Be Co		John Balcer Method of Disposition		10	719 0	•	Stre	per or Rural Rout eet, Ba	alti	•	MD	21224								
Baltimore, MD 21 bearnit Pages I and 2 should I popartment of Health and To is man important: If iren 27 is man njury or other traumatic even		1 X Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	pecify:		ory or other Ly Hi 22. Nar	11	s of Facility	6-27-0 Bradley	06 1 7-Asl	Middle ntonFu	e R	iver, MD ral Home								
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the	death. Do no	PA,	2134	Will	low Spi	ring	Road,	, 2									
/Medical xaminer	1	Immediate Cause (Final disease or condition resulting in death)	Cardiac Arrh									Death								
	miner	Examiner	Examiner	Examiner	Examiner	Examiner	Examiner	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequence. Due to (or as a consequence)									
execur an and al - tra		X UNPENDED	d AMENDED item	#23a,PI	I,27,pe	erME,g857	, 7/12/0	06 TT												
		F FEMALE: 3b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Uni	4 Pregnant at tim	. C. I. alla		death 3	Ectopic	pregnancy		23d. Date of o Month	-	ay Year								
P.O. I es that the signed by the be detached	d by Phy	d by	d by	ρ Ω	δ	Part II. Other significant condit Seizure Disord	-	ut not resultin	g in the und	lerlying cause	given in Par	1	Yes 2	No 3	Prob	he cause of death?				
Division of Vital Records, To the Hospital or Attending Physician: The law requirt within 24 hours after death To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should be a completely filled in by the funeral director, page 2 should be a completely filled in by the funeral director.	Completed				-	26 Plan	o of Dooth /	1 🗸	Was an autopsy performed Yes 2	pr ₫? de		topsy findings available completion of cause of s 2 No								
/ital sician: sician: sis certi	e Be	25. Was case referred to medical examiner?1 ✓ Yes 2 No	1 territals	2 🗸 ER/0	utpatient		Othor:	Check only one) Nursing Home	5 Res	sidence 6	Other									
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.		27. Manner of Death 1 X Natural 5 Pene	stigation	·	Time of Inju	1	yes 2	No		injury occurre										
E 8 5 E (Certification:	3 Suicide 6 Cou 4 Homicide dete	ld not be 28e. Place of Injury (Specify)					or T	own, State)		ral Route Number, City								
To the Hos within 24 h To the Fun	Medical	(Check only Germying F	hysician: To the best of my ki aminer:On the basis of examin and manner stated	nowledge, de nation and/or	ath occurre investigatio	d at the time, on, in my opinio	late and pla- n, death occ	ce, and due to th curred at the time	e cause(s) e, date and	and manner in place, and du	as start ue to the	ed. e cause(s)								
To To	Me	29b. Signature and title of certific		n		29c. Licen O.C	se number			Date signe une 24, 20		nth, Day, Year)								
		30 Name and address of persor Carol Allan, MD As	n who completed cause of deal ssistant Medical Examir		Penn St	reet, Baltin	nore, MD	21201												
Sta Registr	1.0	31. Date filed (Month, Day, Year)		10	Soc	de														
DHMH 17 Rev 1/200		30(10			RIGINAL															

The

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eodor	e Brown		State of Maryland / Department of Certificate of Registrar			ind N	/lental	Hygiene	Reg. I	No. 20	06 2027	
	Physicia I Exami		1. Decedent's Name (First, Middle,Last)					Date of I Month	Da		3. Time of Death 1004 hrs	
-itte	II Examin		Theodore Brown 4a. Facility Name (if not institution, give street and number)	41	b. City, Town,	or Loca	ation of De	June 18	3, 200	4c. County of De		
			902 Spa Road #A		Annapolis	3				Anne Arund	el	
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	_	If Under 1 Y		Under 24		Birth(N		Birthplace (State or eign	
D	irector		216-22-2841 XM 2 F 78 Y	rs.	Months D	ays	Hours	Apr	7	1928	CountryMaryland	
	ž	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	atio	n .						10d Inside City Limits	
	10w any		Maryland Anne Arundel Annapol								1 X Yes 2 No	
	arylan Sa-f st at onc	흸	10e. Street and Number	_	10f. Zip Code	=			10g.	Citizen of What Co		
:	ith the Maryland 23a or 28a-f show notified at once.	Directo	902 Spa Rd.		214	01				USA	L	
:	n with	era F		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					No-	14. Race - Am White, etc	erican Indian, Black,	
	or ite	Funeral	1 X Yes 2 No					erto recari, etc.)				
	2 hours afte "natural", Examiner	à	3 Widowed 4 Divorced If Yes, Give Year or 1 1 1. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedential Decedential Completes 16b. Decedential Completes 16b		Yes 2X I			Specify: Black nd of work done 16b. Kind of Business/Industry				
	72 hou	etec			st of working I					,		
929	rithin 72 ene er than Medical	Completed	12th 0 Si	g	n Tec	h			- 1	City of	Annapolis	
215-0036	filed w Hygi d othe		17. Father's Name (First, Middle, Last)					ame (First, Midd 5 E • B1		,		
212	uld be Menta marke even	o Be	William H. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling	Address (Str					r, City or Town, Sta	ate, Zip Code)	
MD	2 sho h and 27 is rmatic	T								. 21401		
ē,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Inportance of Health and Mental Hygiene Inportant: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a Method of Disposition 20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or			cemete	·	Date	- 1	0c. Location - City	or Town, State	
imo	Pages nent o ant: I or oth		4 Donation 5 Other Specify: Marylar					5-23-06			ille, Md.	
Baltimore,	ermit Separti mport njnry		21. Signature of Funeral Service Licensee	v m	ame and Addr	ess of F Se	& Scility	ons Moi	tu	ary, P.	Α.	
	ysician	-	23a. Part I. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							1401 Approximate Interval		
. II	Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive Atherosclerotic Cal	rdio	ovascular [- Disea:	se				Between Onset and Death	
X	aminer		or condition resulting in death) Due to (or as a consequence of):	-								
		Ŀ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated					· ·				
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	cate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy							23d. Date of deliv	ery	
. 68	certifical inding ph	Physician/N	past 12 months?		al death ner (Specify)	3 E	Ectopic pre	egnancy		Month	Day Year	
Box	death the atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown	Ott	iei (Specify)				_			
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of Vital Records,	aw rec nas ber 2 shou	Completed						a	utopsy erforme	prior t	autopsy findings available to completion of cause of	
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ita	sician: s certi irector	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	ent		Oth	er 🗔	eck only one) ursing Home 5	Re	sidence 6 🗸 Ot	her: Scene	
of <	ding Phy After thi funeral d	. To	1 ✓ Yes 2 No Impaler 2 Ervourpair 27. Manner of Death 28. Date of Injury (Month, Day Year) 28b. Time of Month, Day Year)				t Work?			v injury occurred		
		ation	1 V Natural 5 Pending 2 Accident Investigation		1	Yes	2 No					
Division	pital or Att ours after de eral Direct filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	tree	et, factory, offic	ce build	ing, etc.		on (Stre		Rural Route Number, City	
Ö	spital nours a neral	Seri	4 Homicide determined (Specify)					_		-		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc (Check only one) 2 Medical Examiner: On the basis of examination and/or investi									
	To the Within To the	Medical	and manner stated 29b. Signature and title of certifier		29c. Lice					9d Date signed (
		_	anoth.		0.	C.M.E	≣.			June 19, 2006		
	+1		30. Name and address of person who completed cause of death (Item 23a)									
	0				treet, Balti	more,	MD 21	201				
·	S	tate	31. Date filed (Month, Day, Year) 37. Registrar's Signature	0.4	M.							

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08:47AM une 2000 Charles Ervin Chaffman, Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore St. Agnes Hospita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep. 16, 1959 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 46 Months 10XM 2□ F Maryland Director 219-58-4410 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other than "naturel", or itame 23a or 28a-f ehow vent, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Lansdowne MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3225 Kessler Road 21227 United States Funeral filed within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) Construction Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be d 2 should be fi h and Mental H 7 is marked otl Dorothy Leisher Clarence E. Chaffman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 a Depertment of Heelth ar Important: If item 27 is eny Injury or other trau ance. Tammie C. Chaffman - Wife 3225 Kessler Road, Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State 6 - 28,20064\☐ Dogation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD A Funeral Service Licenta 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer of tonsi · metastatic scuamous cell **Physician** 6 mio /Medical Due to (or as a consequence 👌 Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the ettending physicien and the for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 □ No 3 ☐ Probably 4 ☐Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 1 ☐ Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 100 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification; Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours efter death Funerel Director; 6 Could not be determined within 24 hours efter dea To the Funerel Directo 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 35254 6/24/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ante Miller 200P CM BALTIMORE MND 21229 QUE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 8 2006 Colores . Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Conway Derome Allen 5:50 a. M 6 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Balto 5307 Maple Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months X□M 2□F 212-42-9514 64 Yrs. Md Director 2-1-1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at 14 Yes 2 □ No Director Md N/A Balto 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5307 Maple Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk College (1-4or 5+) /A Hygiene. Elementary/Secondary (0-12) Porter 8th grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Be Harry Conway, Sr Inez Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth ar
Importent: If Item 27 le
eny injury or other treu Dorothy Conway - Wife 5307 Maple Avenue Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Loudon Park Cemet 6-29-2006 Balto, Md 4 ☐ Donation = 5 ☐ Other (Specify) 21. Signature of Furural Service Licensee 22. Name and Address of Facility March F.H. West 4300 Wabash Ave. Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Von-small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to, as a consequence of Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28a. Date of Injury (Month, Day Year) Director: After this in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Maching Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) D0061040 1006 MD PLD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD PLD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 282006

Physic	ian	1. Decedent's Name (First, Middle, Last)	State of Maryland / D 6 per verb., G856		2. 🗆	ate of Death		3. Time of Death		
/Med		Joseph	Cutter	9		Month Da	2 00 6	0200 A		
Exami	ner	4a. Facility Name (If not institution, give str		4b. City, Town, or I	1	40	. County of Death			
Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs. 8, D	ate of Birth	O. Piet			
Director		216-36-6008 1 I	w 2□ ⊑	rs. Months Days		Feb 27, 19	9. Birti 940	place (State or Fore intry) SC		
pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town			10021,11	0.10			
death with the Maryland me 23a or 28a-f ehow r must be multified at	ţŏ	MD	Toc. Oity, Town		LTIMORE			10d. Inside City Lim 1 ☐ ¥es 2 ☐ f		
or 28a	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Cit	tizen of What Cou			
th with	a D	3605 BATEMAN AVENU	E		21216			S.A.		
itame	nuel		. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify) Mexican, Puerto Rican	(es or No-	14. Race - Amer Black, White			
a 0	by F	1 N¥ever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Ye s 2 ☐ No If Yes, Give Year or Dates:	_	Specify:		Specify:	White		
"naturel"	ted	15. Decedent's Educa	tion 16a. I	Decedent's Usual Occupat	on	16b. K	ind of Business/Ir			
	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)) JOB		
her th		9 17. Father's Name (First, Middle, Last)			DY MAN					
od of	Be	1.1 Patrier's Name (Pilst, Middle, Last)			8. Mother's Name (Firs	t, Middle, Maiden	Sumame)			
nd Men marke	10	19a. Informant's Name/Relationship (Type	, Print) 19b.	Mailing Address (Street an	UKN d Number of Bural Bou	to Number City	Town Chair T	- 0: //		
alth a 27 io		SAMUEL NEAL CARE-F			N AVENUE BAL			Code)		
BAITIMOTE, MARYIANG 2121 permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other traumatic event, In Ma		20a. Method of Disposition 1 ☐ Burial 2 ☐ Xemation 3 ☐ Rem	20b. Place of I	Disposition (Name of crematory or other place)	Date	20c. Lo	ocation - City or Te	own, State		
		4 □ Donation 5 □ Other (Specify)	noval from State B.	AYVIEW CREM E	TORY 06	/02/06	N	ID		
		21. Signature of Fune all Service Licensee	2 M	22. Name and Address	of Facility Metropolitan Ch	anal P.C				
. L		23a. Part1. Enter the disease, or complication shock, or heart failure. Listonly one	Tylling	1639 No	orth Broadway B	altimore . M	aryland 212	13		
hysician /Medical xaminer		Immediate Cause (Final disease or condition resulting in death)		Interval Between Onset and Death Day						
ohysicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of							
attending pl	/Mec	IF FEMALE:	If yes, outcome of pregnancy							
ed by the atten detached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 September 1 September 1 September 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		2	3d. Date of delive Month	ry Day Year		
	by P	Part II. Other significant conditions contrib	outing to death but not resulting in ti	ne underlying cause given	n Part I. 23	Be. Did tobacco us	se contribute to th	e cause of death?		
gned t						1 □ Yes 2 🖟	ZNo 3□Prob	ably 4 DUnknov		
en signed t					24	a. Was an autopsy	24b. Were autop	osy findings availab		
hes been signed t e 2 should be det	du e				10	performed? Yes 2 No	death?	pletion of cause of		
ate hes been sign page 2 should be	Completed					k only one				
certificate has been signed trector, page 2 should be det	Be	25. Was case referred to medical examiner?	nital:	100	6. Place of Death Chec)		
this certifical director,	To Be	examiner? 1 Yes 2 No Hosp	1 Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other:	4 Nursing Home 5			Describe how injury occurred		
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nding rnysician: lath. or: After this certific ne funeral director,	edical Certification; To Be	examiner? 1	28a. Place of Injury - At home, farm	atient 3 DOA Other: le of iny M 28c. Injury at Work? M 1 Yes (street, factory, office	4 Nursing Home 5 28d. De 2 No 28f. Loc	escribe how injury cation (Street and y or Town, State)	occurred Number or Rural	Route Number,		
Physician: this certific ral director,	ledical Certification; To Be	examiner? 1	28a. Place of Injury (Month, Day Year) 28b. Place of Injury - At home, farm building, etc. (Specify) 28c. Place of Injury - At home, farm building, etc. (Specify)	atient 3 DOA Other: le of iny M 28c. Injury at Work? M 1 Yes leath occurred at the time, or investigation, in my opini	4 Nursing Home 5 28d. De 2 No 28f. Loc Cit, date and place, and due on, death occurred at the	cation (Street and y or Town, State) to the cause(s) a e time, date and y 29d. Date	Number or Rural and manner as sta blace, and due to signed (Month, L	Route Number, Ited. Ithe cause(s) Day, Year)		
nding Physician: The law requires ath. Trather this centificate hes been sign ne funeral director, page 2 should be	Medical Certification; To Be	examiner? 1	28a. Place of Injury - At home, farm building, etc. (Specify) 28n. To the best of my knowledge, common the basis of examination and/or and manner stated.	atient 3 DOA Other: le of iny M 28c. Injury at Work? M 1 Yes leath occurred at the time, or investigation, in my opini	4 Nursing Home 5 28d. De 28f. Loc Cir. date and place, and due on, death occurred at the	cation (Street and y or Town, State) to the cause(s) a e time, date and y 29d. Date	Number or Rural and manner as sta blace, and due to signed (Month, L	Route Number, Ited. Ithe cause(s) Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 14, 2006 4:38 Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June | 12, 1943 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1XM 2□ F Virginia 63 578-56-3665 Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 9211 Stuart Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No 1960 If Yes, Give Year or Dates: 1963 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married 1960-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced 1963 **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waste Company Truck Driver if Health and Mental Hygin item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucille Johnson William Coleman 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8315 Artillery Dr., Woodford, VA 22560 (Cousin) Lelia L. Baker 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 6/26/06 Triangle, VA 4 Denation 5 Other (Specify) Ouantico Nat. Cemetery 21. Signature of Funeral Service Licensee C.W. EDWARDS FUNERAL HOME BOWLING GREEN, VIRGINIA 22427 ennis Monteen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tente Myo cardeal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hemo while e Kenn Ayean 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1- Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0055120 June 14 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard Palmer mD 1328 Southern avenue SE furte 310 Warhington De 20032 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 282006 Letter is a Registrar

			1 - For State Registrar		Maryland / Depa	artment rtificate				giene () Reg. No.	06	20280
П	Physici	20	1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		CHARI	LES RAYM	OND CLARK				June		2006	4:55 P. M
	Examir	ner	4a. Facility Name (If not institution,		or)	4b. City, To	wn, or Loc	cation of D	Death	4c. Coun	ty of Death	
			201 N. Somerset				isfie				merset	<u> </u>
	Funeral		5. Social Security Number 216–20–4603	.Sex 7.7 12X]M 2□F	Age (In yrs. last birthday) Yrs.	If Under 1 Months E		Under 24 lours M	Min. (Month, Da	v. Year)	Cou	
	Director		Usuel Residence of Decedent		80 Yrs.				June 3,	1926	Mary	/land
	yland		10a. State 10b. County		10c. City, Town or Lo	cation					-	I0d. Inside City Limits
	Mar B-f st	tor	Maryland Somer	set	Cri	sfield						1 Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of	f What Cou	ntry?
	23a c		201 N. Somerset	Avenue			2181	.7		U.S	.A.	
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13. \s?	Was Deceden	t of Hispa Cuban, M	nic Origin'	? (Specify Yes or No uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
36	hours after death with the Maryland tural', or Itama 23a or 28a-f show al Evanifier must be rediffed at	by Fu	1 Never Married 2 Married	1 1 TXYes 2 If Yes, Give	[□] [№] 9/1/50	1 □ Yes 2 □		pecify:			ity: Whit	
8	hours tural',		3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates	12/3/30	dande Herel C						
5	Pan an	Completed	(Specify only highest	grade completed)	(Give	dent's Usual C kind of work of DO NOT use i	done durin	n ng most of	working	16b. Kind of	Business/In	dustry
212	filed within Hygiene. ther then " int, the Mer	E O	Elementary/Secondary (0-12)	College (1-4o	Owne					Oil (Compan	7-7
b	e filed al Hygi other vent, L	Bec	17. Father's Name (First, Middle, La	st)			18.	Mother's	Name (First, Middle,			<u> </u>
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg item 27 is markad othe other traumatic event,	10	Edward Clark					Cathe	erine Pula	ski		
Jan	2 sho and is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (S	treet and	Number o	r Rural Route Numbe	er, City or Town	, State, Zip	Code)
	ss 1 and 2 of Health item 27 i		Bobbie Willis (Companion)		V. Some	erset	Aver	nue - Cris			
0	Pages 1 nent of H ant: if ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 ②☐ Cremation 3		20b. Place of Dispo cemetery, cren	natory or othe	r place)		Date	20c. Location	,	
Baltimore,	it. Pa rtmer rtant njury		* 4 □ Donation 5 □ Other (Spe 21. Signature □ Iner □ ervice Lice	-	Salisbury				/24/06	Salisk	oury,	Maryland
Ba	permit. Pages Department of Important: If I any Injury or once.		Mull	Del.	Bı	Name and A	√ & S	ons E	uneral Ho	me		
			23a. Part1. Enter the disease, or co	adshaw, Jr	ed the death. Do not ente	06 W. Nor the mode o	Main f dving, st	St. – uch as care	Crisfield	, MD 2	21817	Approximate
	Physician		Immediate Cause (Final	ly one cause on each	line.		, ,,		, <u></u>			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		us a fonsequence of):	Ur_						
	Examiner				9,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or a	s a consequence of):							
J. J.	and trans	Examine	Cause (Disease or Injury that initiated events resulting in death) Last								17	
8760,	cate be executed physician and the burial-transit		Due to (or as a consequence of):									
687	death certificate be executed e attending physician and ad for use as the burial-transit	dical		d.								
	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy					224 D	see of delice	
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth	2 Fetal death 3	Ectopic pregr Other (specif					ate of delive onth	ny Day Year
o.	that the de ed by the a detached t	hys	9 Unknown	9□ Unknown		(-,	,,					
٥,	The law requires that the site has been signed by the sage 2 should be detached.	by P	Part II. Other significant conditions	contributing to death	but not resulting in the un	derlying caus	e given in	Part I.	23e. Did to	cco use con	tribute to th	e cause of death?
Vital Records,	w require been sig should b	ed							17 Y	es 2 🗆 No	3 ☐ Proba	ably 4 🗀 Unknown
ဝင္ပ	has be	Completed							24a. Was a	an 24b.	Were autor	osy findings available
Ä		E O					-		autop: perfor1 Yes	med/!	death?	npletion of cause of
/ita	ii clan ; Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26.	Place of 0	Death (Check only or			
£	hysi this c	은	t ☐ Yes 2½∑ No	Hospital: 1 Inpat				☐ Nursing	g Home 5 🙀 Resid	ence 6 🗆 Oth	ner (Specify)
n O	Jing F After funer	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	ay Year) 28b. Time of Injury		Injury at Work?		28d. Describe h	ow injury occur	red	
isi	uttand death ctor: / y the f	icat	2 Accident investigate 3 Suicide 6 Could not	be -	nium. At home form atte		1 Tyes	2 No	206 1 anation (C			
Division of	i or A after Dira d in by	Certification;	4 ☐ Homicide determine	building, e	njury - At home, farm, stre atc. (Specify)	et, ractory, or	rice		28f. Location (S City or Town	n, State)	oer or Hurai	noute Number,
	spita nours neral		29a. Certifier 1 Certifying I	Physicien: To the bes	t of my knowledge, death	occurred at the	ne time, da	ate and pla	ace, and due to the c	ause(s) and m	anner as sta	ated
	To the Hospital or Attanding Physician: within 24 hours atlar death. To the Funeral Diractor: After this certifical completely filled in by the funeral director.	Medical	(Check only 2 Medical Ex-	aminer: On the basis and manner s	of examination and/or invi	estigation, in	my opinior	n, death oc	ocurred at the time, d	ate and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of continer			29c. Li	cense nun	nber	2	9d. Date signe	d (Month, E	Day, Year)
			///	MO)	\square \square	57.	290)	6/-	23/0	6
	A		30. Name and address of person wh	completed cause of	death (Item 23a) (Type, F	Print)	10	M 1	10 1 -1	0	1/ [1	114.0 2.00
	V		31. Date filed (Month, Day, Year)	Carcia-	Prod. M.) <u> </u>	1115	Ma	rKet St.	Vocam	دالر له	7,411) 21851
	Sta Registr		JUN 2 8 2001		trar's Signature	2 0						/
			2 2 200	SALM TRI	Jos Maria	Sand						

State of Maryland / Department of Health and Mental Hygien 2 0 0

2	0	2	8	-

			1 - For State Registrar	Cen	rtificate of Death		eg. No.		
	Physici	an	1. Decedent's Name (First, Middle, L	ast)		2. Date of Dea Month			
	/Medic		Enid	Conte		June	25 2006 3:00p M		
	Examir	er	4a. Facility Name (If not institution, g		4b. City, Town, or Location of D	eath	4c. County of Death		
			13 Orthoridge R	Sex 7. Age (In yrs. last birthday)	Lutherville If Under 1 Year If Under 241	Hrs Doto of Bimb	Baltimore		
	Funeral Director		090-18-9222 Usual Residence of Decedent	1 ☐ M 2 ☑ F 88 Yrs.		Hrs. 8. Date of Birth Ain. (Month, Day APR 8 1	, Year) 9. Birthplace (State or Foreign Country) NY		
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits		
	a-fst	ctor	MD Baltin	nore Lutherv	ille		1 ☐ Yes 2 🛣 No		
	or 28	Dire	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Country?		
	ath w	rai	13 Orthoridge H		21093		USA		
9	72 hours after death with the Maryland neturel', or Items 23a or 28a-1 show dical Examilian must be notified at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married	1 Yes 2 X No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Political Property: 1 ☐ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
003	72 hours "neturel",	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:			Specify: white		
15-	n 72 h	Completed	15. Decedent's I (Specify only highest g	Education 16a. Deceding 16a (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/Industry		
12	within iene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	memaker		Own Home		
p	Hygie other	BeC	17. Father's Name (First, Middle, Las			Name (First, Middle, M			
/lar	should be filed nd Mental Hygi marked other umatic event, I	To	Michael Dubur	nno	Ida	a Schnyde	er		
Baltimore, Maryland 21215-0036	2 2 2 3 3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		19a. Informant's Name/Relationship		ng Address (Street and Number or				
2	and sealth m 27		Nancy Merkle - d	0	rthoridge Road,				
Jore	⊕ ° = ≥		20a. Method of Disposition 1 Burial 2 Cremation 3	Literiovalitoni State	osition (Name of matory or other place)		20c. Location - City or Town, State		
臣			' 4 ☐ Donation 5 ☐ Other (Spec	Chesapeal	ke Crematory 6/	/27/2006	Beltsville, MD		
Ba	permit. Departr Importe any inju		1 tuli	M00986 8	AFA, Stephen b. 3717 Green Pastu	Lohrmann,	PA Torran MD 21296		
			23a. Part1. Enter the disease, or con	mplications that caused the death. Do not enti-	er the mode of dying, such as care	diac or respiratory arre	Towson, MD 21286 Approximate Interval Between		
	Pnysician		Immediate Cause (Final	y one cause on each line.		· · · · ·	Interval Between Onset and Death		
7	/Medical		disease or condition resulting in death)	a Due to (or a a consequence of):			ZWELKS		
ł	Examiner		Sequentially list conditions	Gangrene	of bilate	ral te	et 4 weeks		
	po ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	· .	•	(0.40)		
	and I-trans	хаш	that initiated events resulting in death) Last	c. Diabetes	Diabetes Mellitus Due to (or as a consequence of):				
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68760,	certificate be executed Iding physician and Ise as the burial-transit	Medicai		d. Concord	10000 CO		2 9		
Вох	eath cert attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	Te		23d. Date of delivery		
	requires that the death een signed by the atter hould be detached for u	sicia	in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)		Month Day Year		
P.0	that the de led by the detached	Physicia	9 Unknown						
Ś	ires the signed d be de	by	Part II. Other significant conditions	contributing to death but not resulting in the ur	iderlying cause given in Part I.		acco use contribute to the cause of death?		
orc	v requi	eted	Do Standing 14	Artery Discase		_ 1 □ Ye	s 2 No 3 Probably 4 Unknown		
of Vital Record	2 2 2	ompieted	renipheral	Arrery pisease		24a. Was an autopsy	prior to completion of cause of		
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Ę	Physicien: 1 this certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	04	Death (Check only one			
0	g Phy: er this	- 1	27. Manner of Death	28a. Date of Injury 28b. Time of	t 3 DOA 4 Nursing 28c. Injury at Work?	28d. Describe ho	nce 6 Other (Specify) w injury occurred		
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No				
Division	il or Attend after death Director: A	Certification:	3 Suicide 6 Could not l		et, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number,		
	ital o ris aft rel Di						,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th compietely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death miner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and pla estigation, in my opinion, death oc	ice, and due to the car ccurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Ĺ	29c. License number	29	d. Date signed (Month, Day, Year)		
)	6		1/1/1/	W'	D56623		06-26-2006		
	1'		30. Name and address of person who	completed cause of death (Item 23a) (Type, F	Print)		06-26-2006 MD 21204		
			31. Date filed (Month, Day, Year)	7505 OS(er 8m) 32. Registrar's Signature	VP 1405, 11	MOSMG.	AND SIZOT		
	Sta Registra			Sc. negistrar's signature	de la				
	3	14	JUN 28200	JU KARAGA					

State of Maryland / Department of Health and Mental Hygiene U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05 1:12 AM GURI Camceon 2006 26 /Medical . Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BeHimory City 701 St 7. Age (In yrs. last birthday, If Under 1 Year 24 Hrs. 8. Date of Birth (Month, Day, 5 24 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours Director NIA lary Usual Residence of Decedent 10a. Slate 10c. City. Town or Location iral, or Itama 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Immore City 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Itama 23e or: WENKE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or Itama Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Dock 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Healih and Mental Hygiene. Important: If Item 27 is marked other than "natuu any injury or other traumatic event, I'm Practical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 INTON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame Be UNKNOWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type, Print) Cameron MUNINTAR -Mother 2925 Dalhmore 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location -1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 130 Neal * 4 ☐ Donation 5 ☐ Other (Specify) 04 21. Signature of Funeral Service WHERAL HOME ! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmona Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pe 2 No 1 🗆 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 No the 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 8

2006

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21201

npleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 6 1 - State Registrar Certificate of Death it's Name (First, Middle, Last 2. Date of Death 06-21-2006 Name (Innot institution, give street and number) 4b. City, Town, or Location of Death Towson

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Honore 5. Social Security Number 169-42-1098 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 KF 5 Usuel Residence of Decedent 10b. County 10c. City. 10d. Inside City Limits timore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21207 or wood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) usiness industry Elementary/Secondary (0-12) College (1-4or 5+) anager ther's Name (First, Middle, Last) ther's Name (Hirst, Middle, Maide winse formant's Name/Relationship (Type, Prin 19b. Mailing A Press (Street and Number or Rural Route Number, City 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) 5 Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of): es if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner Box 68760, P.0. Vital Records, Division of or Attending r death. Director: δ

Physiclan/Medical

Completed by

Be

Medicai Certification: To

3 Suicide

29a. Certifier

4 - Homicide

Physician /Medical

Examiner

Director

Funerai

Completed by

Be

10a State

Funeral

Director

a' Hygiene. I other then 'natural', or Iteme 23a or 28a-1 ehov vvent, the Medical Evandrat must be notified at

Department of Health and Mental Hygie Important: If itam 27 is marked other tile ony Injury or other traumatic event, Impone.

Physician

Baltimore, Maryland 21215-0036

within 24 hours effer d To the Funeral Direct completely filled in by To the Hospital

> State Registrar

31. Date filed (Month, Day, Year) JUN 2 8 2006

29b. Signature and title of certifier

· us

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of neath (Item 23a) (Type, Print) G-B/mc 6701

6 ☐ Could not be

N. Charles St.

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 950 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Min. Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗗 F Director Usual Residence of Decedent 10c. City, Town or Locatio 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Funeral Was Deceden Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes Give 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced ges 1 and 2 should be filled within 72 hours it of Health and Mental Hygiene. If item 27 is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres Street and Number or Rural Route Number, City 20b. Place of Disposition (Name of 20a. Method of Dispos 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Other (Specify) ineral Service License 22. Name and Address of Facility 21. Signature of Franker ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral ory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Zn shock, or Immediate Cause (Final diseas , or condition resulting in death) TRACRANIAL **Physician** HEMORRHAGE 48 HOURS /Medical Due to (or as a consequence of):

AS A RESULT **Examiner** S—quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ALCOHOL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

Yo the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner Hospital: Other: 2 🗌 No 70 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural
2 Accident 5 Pending investigation 22-08 1 ☐ Yes 2 X No Location (Street and Number or Rural Route Number City or Town, State): 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital 29a. Certifier

State Registrar

JUN 282006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Christan

CHRISTIAN MIN

31. Date filed (Month, Day, Year)



MO PHD

29c. License number

D0063500

29d. Date signed (Month, Day, Year)

2006

			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		jiene2 ()	06	20286						
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day	Year	3. Time of Death						
	Physicia /Medic		James Sherwood Eddy	Juli		2006	03 724						
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		46. Count	y of Death							
			9590 MUIRKIRK RD. , APT. 101 LAUREL			E GEOR	RGES						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 163.38.3654 1 M 2 F 52 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign						
	Director	-		JULY 19	1953	PA							
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits						
	Manyl 1 ehc	ō	MD PRINCE GEORGES LAUREL				1 ☐ Yes 2XX No						
	the 28e	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of	What Cour	itry?						
	3a or		9590 MUIRKIRK RD. , APT. 101 20708										
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe			ce - Americ							
9	or ite	Ē	Armed Forces? If Yes, specify Cuban, Mexican, Puerto I 1\(\frac{1}{\text{X}}\) Never Married 2 \(\text{Married} \) Married If Yes, \$\frac{1}{\text{X}}\) No If Yes, \$\frac{1}{\text{X}}\) No Specify:	Hican, etc.)		ck, White,	etc.						
8	rai', c	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specia	y: WHIT	E						
5-0036	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28e-f ehow the Medical Exandrer must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	ng	16b. Kind of B	lusiness/Ind	dustry						
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	led w tygien her ti		12 2 MENTAL HEALTH WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name	/First Middle		TH CAR	E						
ano	be fi	Be	ALEXANDED CHEDWOOD EDDY	,	Maidell Sullial	110)							
Ĕ	d Me d Me mark maric	ပ	ALEXANDER SHERWOOD EDDY EDNA SM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I DER	City or Town	State Zin	Codel						
Maryland	d 2 s th an 17 is i				. 1	, otato, zip	Occup)						
	1 an Heal am 2		20a Method of Disposition 20b. Place of Disposition (Name of D		20c. Location	- City or To	wn, State						
<u>o</u>	ages ont of t: # If		1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State BAYVIEW CREMATORY, INC. JUN 22	2006	DA1 71110D	E 145							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if itam 27 is marked other than "natural; or items 23a or 28e-f ehow any injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		BALTIMOR	E, MD							
Ba	Depar Impo any ir		KI GREGORY FINK MO1148 FINK FUNERAL HOME, P	.A.	F MD 0	1001							
			K CRECORY FINK M01148 426 CRAIN HWY. S., G 23a. Part 1. Ener the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart lailure. List only one cause on each line.	r respiratory arr	est,	1001	Approximate Interval Between						
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-	ertific ding p		IF FEMALE: 23c. If yes, outcome of pregnancy										
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P.0.	the a	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)										
	law requires that the death certific as been signed by the attending f 2 should be detached for use es	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use con	tribute to th	e cause of death?						
ds,	uires tha signed I	d by	Diab etes	1 🗆 Ye	es 2 No	3 Prob	ably 4 Dinknown						
Sor	v requir been si should	lete		24a. Was a	n 24b	Were auto	psy findings available						
Records,	The lav	Completed		autops	med?	prior to cor death?	npletion of cause of						
a	in: Ti ificate or, pa	e Co	25. Was case referred to medical 26. Place of Death	1 Yes		1 🗆 Yes	2 No						
₹	ding Physicien: The I h. After this certificate ha funeral director, page	To Be	exampler? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor			er (Specifi	()						
of	Phy er this		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	28d. Describe ho			7						
ion	ttending death. ctor: Aft y the fun	atlo	1 ØNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No										
Division of Vital	Atte er de recto by th	tific	3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		ber or Rura	l Route Number,						
ō	tel or rs afte el Dir	Certification:	Dullang, St. (opposity)		., σταιογ								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.										
	the H iin 24 the F iplete	Medical	one) and manner stated.										
	To To	2	29b. Signature and title of certifier 29c. License number	2	9d. Date signe	a (Month, i	Jay, Year)						
7	1		14002597	-7 .	I chang	27	72006						
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(Lo.	. 1	us	- land						
	1		SKVALY Sylve To 3 col / Sp. ftl Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature		y.	1-11	ying						
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8 2006 32 Registrar's Signature		U								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 24, 2006 **Physician** 8:40 P Edgar Charles Evans, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Months Days Hours Min. Feb 23, 1928 9. Birthplace (State or Foreign Lancaster, Pa 5. Social Security Number 6. Sex **Funeral** XX M 2□ F 210 12 9196 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2XXXVo Directo Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7904 Pinewood Drive 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 MXes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. s filed within 72 hours after I Hygiene. other then "natural", or Ite 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2XXXVo <u>^</u> Specify: XX Widowed 4 □ Divorced Completed 15. Decedenl's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 Ie marked o any Injury or other traumatic eve Helen Trapnel Edgar Charles Evans, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas E. Evans (Son) 4088 Longfellow Street, Allentown, Pa 18104 Baltimore, 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

June 29pate2006 20c. Location - City or Town, State Mellinger's Mennonite Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Lancaster, Pa 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signalure of Funeral Service License Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MENINGIFES 7 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Las! Due to (or as a consequence of) Examine g physicien and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate hes been signed by the atte , page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> OBSTANIT WE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown LMRUNIL Lunn Completed 24b. Were autopsy findings available prior to completion of cause of death? CORUNA AY ARTERY autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Nnpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? Hospitel or Attending Pl 24 hours efter death.
 Funeral Director: After the 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide of the Hc.
within 24 hours
To the Funeral Division? 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38388 (0-25.0(0 700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunil Nachnani, 8926 Woodyard Road Suite 601, Clinton, MD 20735 32. Register's Signature 31. Date filed (Month, Day, Year) State JUN 282006 > Registrar

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o Plancici		1. Decedent's Name (First, Middle, Last)	Douin	2. Date of Death Month	The second of th	<u>U</u>	
Physicia /Medic		HOWARD JOSEPH FRANCE, SR.		June 27		Л	
Examin	er		or Location of Death	1	4c. County of Death		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth (Month, Day,	Baltimore County 9. Birthplace (State or Foreign Country)		
Director		219-28-6682	Hours Min.	May 17,	1928 Maryland		
arylan show	<u>_</u>	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit		
he Ma 28a-f	ecto	Maryland Baltimore County Towson 100. Street and Number 100. Zip Code		10	lg. Citizen of What Country?		
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death ms 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of I If Yes, specify Cub		pecify Yes or No-	14. Race - American Indian, Black, White, etc.	_	
ie, ividity idilical (12.13-1000) I and 2 should be filed within 72 hours after death with the Maryland fleatih and Menrial Hygene. Ifea 27 is marked other then "natural," or Items 23a or 28a-f show other traumatic event, the Madrial Examinar must be notified at	þ	1 Never Married 2 Married 1 Never Married 1		o riidari, etc.)	Specify: White		
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INICA Id 2 st Ith and 27 is r traur		Margaret B. France (Wife) 900 Weatherbe			farvland 21286		
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mit, Pages partment of I portant: If its y injury or o		1 □ Burial 2 Thermation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Green Mount Crema		8/2006	Baltimore, Maryland		
partimore, into permit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Fundal Servick ichasee 22. Name and Address Mrt cho 11-	ess of Facility	d Funeral	Homo Inc		
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To the Hospital or Attending Physician: The Within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page	ertiflcation:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)		
pital purs a erel Dilled i	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the ti	ime date and place	and due to the cau	usa(s) and mannar as stated		
e Hos 124 ho e Fun letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occu-	rred at the time, dat	te and place, and due to the cause(s)		
To th withir To th comp	Me		ise number		d. Date signed (Month, Day, Year)		
_1		John W. Varwemp D	2064	7	6/27/06		
Q.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	st Casta	/.000 m			
Sta	ete.	John Bowie, M.D., 6701 North Charles Stree	sulte	490Z, To	wson, Maryland 21204		
Regist		JUN 2 8 2006					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#11512000FMac93606628/206neHt of Health and Mental Hygiene For State Amend item#1, perMD, G857, 7/25/06 TT Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IRMA C. FISHBEIN **Physician** JÜNE 2006 FISHBEIN-26 7:03 P M /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3401 OLD FOREST ROAD BALTIMORE BALTIMORE 8. Date of Birth Month, Day, Year, 08/17/1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 F MD 74 215-32-6615 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3401 OLD FOREST ROAD 21208 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Maditical Faces and once. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify WHITE ģ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COHN **JOSEPHS** ETHEL NATHAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVIN L. FISHBEIN / HUSBAND 3401 OLD FOREST ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 06/27/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1. Mals Com 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTINS tmmediate Cause (Final disease or condition resulting in death) Lung Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tany, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be execut the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached i 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed, 2 No 1 ☐ Yes 2 ☐ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 1 Naturat 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. М 1 TYes 2 No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check onli and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D0055065 June 27, 2006 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Martin J. Edelman, M. University of Maryland 22 S. Greene St N9E08 Baltimore MD 21201

State Registrar 31. Date filed (Month, Day, Year) JUN 2 8 2006



State of Maryland / Department of Health and Mental Hygiene 2006 20290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year illian June 1907 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW Medical Center Baltimore Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 27, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 218-18-6711 81 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Moye. r then "naturel", or items 23a or 28a-f ehov The Medical Examiner must be notified at XXYes 2 □ No Directo Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5410 Creston Ave. 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes X2 K No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes X2X☐ No Specify: Specify. White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 10 yrs. Homemaker permit. Pages 1 end 2 should be filed w Department of Health and Mental Hygier Importent: if item 27 is marked other th eny injury or other traumatic event, III.a 2002. Homemaking-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chester S. Pugh Lillian Gensler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy J. Brylke (Nephew) Creston Ave. Baltimore, Md. 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 6~28~2006 Baltimore, Md. 21. Signature of Fuer Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Onset and De Immediate Cause (Final disease or condition resulting in death) Physician Stroke 8 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physicien a s the burial-I P.O. Box 68760 Physician/Medical 98 attending p for use es IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has birector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes ♥ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital Other: 1 🗌 Yes Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ÷ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certaier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AMANDADORN 4940 Eastern Avenue Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 282006 Registrar

					State of Maryland / Department of Health and Men	ntal Hygien	9006	20291
	_			State Registrar	Certificate of Death	Reg. N	6.000	20201
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		Funeral	 -	5. Social Security Number 6. Sex 10-20-8176	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. M 2 D Months Days Hours Min.	Date of Birth Month, Day, Year	COL	place (State or Foreign
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		ith the Marylan or 28a-f show	tor	10a. State 10b. County	A Baltimere)		10d. Inside City Limits 1 ■ Yes 2 □ No
			Director	10e. Street and Number	00 h 101 At 101. Zip Code	10g. C	itizen of What Cou	intry?
		ter death w Items 23a	Funeral		2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cubay, Mexican, Puerto Rica	Yes or No-	14. Race - Amer Black, White	
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60	Baltimore,	그 문문을		4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee	Ring mem, tark 6-20-	Fuditi		,
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		Physician		sho k or ha hailure. List only one Immediaty Cause (Final disease or condition	rations that caused the death. Do not enter the mole of dying, such as cardiac or reseause on each, line.	spiratory arrest,		Interval Between Onset and Death
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	Vital	siclan: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death Cl ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		o Marin (0	Araie
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B	Division	death death ctor: y the	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		Location (Street a City or Town, Star		al Route Number,
1	ā	Hospital or A thours after Funeral Directely filled in b	O					Plated
M		= (4 = 0	Medical	one)	ician: To the best of my knowledge, death occurred at the time, date and place, and er: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
		To the Within To the	Σ	29b. Signature and title of certifier Mut B. N.	Jaidelins 29c. License number	29d. D.	ate signed (Month,	. Uay, Year)
•	1	3		30. Name and address of person 100 mg	MADWAD 1000 E. Rager	Street	Balt r	107-12AV
	-3	Sta Regist		31. Date filed (Month, Pay Year) 8 20	32. Registrar's Signature		-	

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 20292 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Grafton Harry 4:03 AM 26, June 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (127 08/1960 Birthplace (State or Foreign MD Country) 5. Social Security Number **Funeral** 1.3M 2□ F 220-82-4595 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show MD Harford Aberdeen 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? nd 2 should be filed within 72 hours efter death with lift and Mertal Hygiene.
27 le marked other than "naturet", or iteme 23a or traumatic event, the Medical Examinar must be traumatic event, the Medical Examinar must be 21001 732 Rand Street U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Yes. Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Warehouse 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Ellis Carter Pages 1 and 2 should be Joan Doering ၉ 19a. Informant's Name/Relationship (Type, Print) Ginny Grafton/Wife 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Rand Street Aberdeen, MD 21001 permit. Pages 1 and 2.:
Department of Heelth at Important: If Item 27 le eny injury or other traugone. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory Inc. 2006 20c. Location - City or Town, State 20a. Method of Disposition Jun 29 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 remains of a Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-MO1443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emore 12 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 Due to (or as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed Se Sovere PSIS Due to (or as a consequence of): Vital Records, P.O. Box 68760 ettending physicien for use as the buria Physician/Medical neumoni IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? feet has autopsy performed? of ivdrug abuse to bue a souse and alcoholist 1 Ves 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Impatient 2 ER/Outpatient 3 DOA Division of this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident I Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours efter of Funerel Direct 4 | Homicide pelli 29a, Certifier 1/2/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 26, 2006 5-1 Do053568 Memorial bospital 30. Name a ho completed cause of death (Item 23a) (Type, Print) Thompson 31. Date time (Month, Day, Year) 32. Registrar's Signature State NUC 8 Registrar

GRAFTON

ME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 25 2006 5:25 A GETZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/21/1924 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 218-14-5892 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f ahow the Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 PENNY LANE 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other then "na eny Injury or other traumatic event, Ita Medis 2008. Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** ART TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRVING SHUR ROSE TRAUB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 PENNY LANE - BALTIMORE, MD 21209 MARVIN GETZ / HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State BETH EL MEMORIAL PARK 06/27/2006 RANDALLSTOWN, MD 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mals Cen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVAVIM Concer Rons /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this : After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funaral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the hast of my knowledge death occurred at the time date and place, and due to the cause(s) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 Me, us June 25,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ule St. Bolts and 21204 V Riley Sme 6701 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2006 Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			giene Reg. No.	006	20294
			1. Decedent's Name (First, Middle, L	ast)		· · · · · · · · · · · · · · · · · · ·		2. Date of De	ath		3. Time of Death
	Physici /Medio		William Thomas	Griffitts,	Sr.			June :	24, 200	Year 16	1:35AM M
	Examir		4a. Facility Name (If not institution, ga	ve street and number)		4b. City, Town, o	r Location of Dea			nty of Death	
			Heritage Nursir	<u> </u>		Baltin				ltimor	
п	Funeral		5. Social Security Number 6. 216-72-5018	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	ıy, Yəar)	9. Birthr	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	Χ	46 Yrs.			June 2	1, 1960	Mary	land
	yland 10w		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mar-1 st	ţċ	MD Baltin	ore	Dunda	1k					1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	23a 23a	Funeral Director	8335 Kavanagh R	oad		2122	22		U.S	S.A.	
	r dea	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 14. R	lace - Americ	
36	ours after death with the Marylan rel', or items 23a or 28a-f show Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐	No	1 ☐ Yes 2 ᡚNo	Specify:		Spec	cify:	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Hems 23a or 28a-f show ont, The Madical Examiner must be notitled at	pa pa	15. Decedent's I	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of		ite
15	n "na	Completed	(Specify only highest g	rade completed)	(Give	kind of work done of DO NOT use retired	during most of w	orking	TOD. KING OF	Dusinessin	dusily
212	d with giene. ar thar	E O	Elementary/Secondary (0-12)	College (1-4or !	D+)	Machine	Operator	r	Polv S	eal C	orporation
	m - 0 &	Bec	17. Father's Name (First, Middle, Las	t)				ame (First, Middle,			
<u> a</u>		10	James philand	er Griffi	tts		Hatti	e Ruth	Chapma	n	
Maryland	2 sh and Is m	6 1	19a. Informant's Name/Relationship			ng Address (Street	and Number or F	Rural Route Numbe	er, City or Tow	m, State, Zic	Code)
	C - O L	1 3	Mr. James Griffit	ts- Brothe		Kavanagh	Road Di		arylan		
Baltimore,	0 0 = =	1	20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3	☐Removal from State		matory or other plac	·	Date	Zous o		
tir			* 4 □ Donation '5 □ Other (Spec 21. Signature of Funeral Service Lice			Service C					ryland
Ba	permit. Departn Importe any inju		1 - Clas	to C	ani D		Funeral			Dunda k, Ind	alk,MD 2122
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each li	the death. Do not en ne.				rrest,		Approximate Interval Between
	Priysician	4	Immediate Cause (Final disease or condition resulting in death)	a. RECEL	RRENT.	DENDE	209L	OMA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			200000000000000000000000000000000000000			
		<u>.</u>	S- uentially list conditions,	b. 5 1 Z	a consequence of):	150121	上人				
	ted nsit	교 교	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	AR	ASIA						
-	arecu n and al-tra	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	N				_	
8760	cate be executed bhysician and the burial-transit	dical		a ENL	PRCED	PROS	TAT	E			
9	tiflicat ig phy as th	υ :									
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. D	Date of delive	ery
_ •	o death	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at		Other (specify)			٨	Month	Day Year
P.0	at the de d by the a stached	Phy	9 Unknown								
	ires tha signed I be del	by	Part II, Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.				ne cause of death?
ord	v requir been s should	ted						1 1	res 2□No	3 🗌 Prob	abiy 4 Minknown
Records,	a law has b e 2 si	Completed						24a. Was autop	osv	Were autor	psy findings available mpletion of cause of
E F									rmed? 2 D No	1 Yes	2 No
Vital	Physicien: Th this certificete al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ar /	eath (Check only o			
o		- To	1 ☐ Yes 2 ☐ No 27. Manu of Death	1 ☐ Inpatie		IL 3E DOA	4 h Triursing	Home 5 ☐ Resid			y)
on	ding th. After funer	tion	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injury	Work	k? Yes 2 □ No	200. 2000. 190	iow injury occo	21160	
Division	of or Attending safter death. I Director: After d in by the fune	fica	3 Suicide 6 Could not	28e. Place of Inj	ury - At home, farm, str			28f. Location (S	Street and Nun	nber or Rura	I Route Number.
Ö	a after	Certification;	4 Homicide determined	building, et	c. (Specify)			City or Tow	vn, State)		
	Hospite 4 hours Funere	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner sta	f examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the curred at the time, o	cause(s) and n	nanner as st , and due to	ated, the cause(s)
	To the within 2 To the complet	Me	29b. Signature)and title of certifier			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	->-0		Carlin Aa.	MITTERDO.	118	An	7/88	7	61.	210	126
i	0	1	30. Hama and address of person who	completed cause of d	eath (Tem 23a) (Type.	Print)	0	- 2	1	-7/	00
1			Sartin On 1	Selle.	2 000	r last-	y lar	AIN	fall	MA	21222
	Sta		31. Date filled (Month, Day, Year)	2. Registra	ar's Signature	N. J			100 46G		- COUR
	Registr	ar	JUN 2 8 200	16 Stores	Sir Killer						

DHMH 17 Rev 1/2001

		í	For State Registrar	State of Maryl	and / Depa		lealth and M	lental Hyg	•	5 20295
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Leona Grace Gosne	211				2. Date of Dea Month June	Day Year 25, 2006	08:45 A ^M
	Examin Funeral	er	4a. Fecility Name (If not institution, give 5408 Sykesville F 5. Social Security Number 6. Sec.	Road 7. Age (In	yrs. last birthday)	Sykesvi If Under 1 Year Months Days	Location of Death 11e If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dec	ath irthplace (State or Foreign
	Director		218-16-1053 Usual Residence of Decedent 10a. State 10b. County	M 2M F 8:	Yrs. City, Town or Lo		TIOUTS IVIIIT.	8. Date of Birth (Month, Day) May 9,	1925 Mai	ryland 10d. Inside City Limits
	the Maryl.	Director	MD Carroll 10e. Street and Number		ykesvill			1	Og. Citizen of What C	1 ☐ Yes 🌠 No
36	be filed within 72 hours after death with the Maryland and Hylgiene and Hylgiene dether then "natural", or items 23a or 28e-f show other then "natural Examiner must be natified at event. The Madical Examiner must be natified at	by Funeral D	1626 Pine Knob Ro 11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	Dad 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		21784 Was Decedent of Hill Yes, specify Cuba	spanic Origin? (Spin, Mexican, Puerto		Inited Sta 14. Race - Am Black, Wh Specify: W	erican Indian, ite, etc.
215-00	ithin 72 hour ne. nen *natural ne Medical Ex	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a, Dece	dent's Usual Occupi kind of work done o DO NOT use retired	ation furing most of work	ing	16b. Kind of Busines	
2	be filed ital Hygi id other event, I	To Be Cor	11 17. Father's Name (First, Middle, Last) Adam Shaffer		Homen	naker	18. Mother's Name	e (First, Middle, I		
	od 2 :		19a. Informant's Name/Relationship (Ty Roland Gosnell	Husband	1626	Pine Knol	and Number or Rura D Road S	ykesvil	; City or Town, State, Le, MD 21	784
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R 4 □ Ronation 5 □ Other (Specify) 21. Sonature of Funeral Service Licens:	temoval from State	. Carrol	istion (Name or natory or other place 1 Cremato 2. Name and Addres	ory June	27	20c. Location - City o	
Ea Ea	permit, Departr Importe any inji		a. Part1. Enter the disease, of complishoo, or heart failure. List only or	COULD ications that can ed the	Bu	rrier-Que 212 W. Old	een Funer 1 Liberty	Road V		P.A. MD 21784 Approximate
760,	auth certificate be executed with certificate be executed with many attending physician and to use as the burial-transit	lical Examiner	Immedia & Cause (Final disease) r condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	sequence of):	L Wh	l Awl			System Death
O. Box 68	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
ras, P.	equires that en signed b ould be deta	by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	/	the cause of death? Probably 4 Unknown
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DIVISION	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	lural Route Number,
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or in-	occurred at the tim vestigation, in my op	inion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)
4			1			06	7231		od Date Signed (Most	1
	Ste		30. ame and orders of person who co	mpleted cause of death (ruth C	Print)	treat l	WESTHIL	ister Mi	21157
	Registr		IIIN 9 8 20		K A	and I				

DHMH 17 Rev 1/2001

ORIGINAL

				For State Registrar		State of	Maryla			nent of F	lealth and Death	d Ment	tal Hygie	201	06	2029
		Physici	ion	1. Decedent's Name	(First, Middle, L	.ast)							ate of Death		ear	3. Time of Death
4		/Medi		Thelma		E		rris				J		7 200		5:45 A M
		Examir	ner	4a. Facility Name (If I	sity S	pecial		40sp	4b.		r Location of De	eath		4c. County of	Death	
		Funeral Director		5. Social Security Nui 231-94-56		Sex 7 1 M 2 TyF 7	7. Age (In y	rs. last birtho	Mor	nder 1 Year iths Days	If Under 24 H	in. (A	ate of Birth Nonth, Day, Ye	ar)	Counti	ace (State or Foreign
		מי		Usual Residence of D			- / 1					Ма	irch 13	, 1935	V 1.1	rginia
		nylan show	_		10b. County	_	10c.	City, Town o	r Location						10	d. Inside City Limits
		88-1 s	cto	DC	none		Wa	ashing	ton,	DC						1.☐ Yes 2 ☐ No
		with the	Dire	10e. Street and Numb					10	f. Zip Code			10g.	Citizen of Wha	t Count	ry?
		eath	erai	2300 Good	норе к	0ad 12. Was Deced	lent Ever in	1118	3 Was D	20020	lispania Origin?	(Consider)		USA 14. Race	^	- 1 - 4'
	9	or Hen	Funeral Director	1 X Never Married	d 2 Married	Armed Ford	es?	0.5.			lispanic Origin? an, Mexican, Pu	erto Rican	, etc.)		Mhite, e	
	933	ours a ral', o	by	3 ☐ Widowed 4	□Divorced	If Yes, Give Year or Dai	X es:		1 □ Ye	s 2] [] No	Specify:			Specify:	B1a	ack
	21215-0036	within 72 hours after death with the Maryland ane. then "naturat", or items 23a or 28a-f show the Medical Exeminer must be mulfined at	etec	(Specify	5. Decedent's only highest g	Education rade completed)		(G	ive kind c	Usual Occup	during most of v	vorking	16b	. Kind of Busin		
	12	withir ene. then	mp	Elementary/Second none	dary (0-12)	College (1-	4or 5+)			T use retired						
-	9	e filed I Hygi other	Be Completed	17. Father's Name (F	irst, Middle, Las	st)			icvei	worke	18. Mother's N	lame (Firs.	t, Middle, Maid	none den Sumame)		
Harri	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show any righty or other treumetic event, the Medical Examinat must be notified at Once.	To B	George Ha	rris						Alma					
410	lan	and Is me		19a. Informant's Nam	,						and Number or					
	e)	1 and lealth sm 27 sher ti		Alise H. I		/ Sister	201	230 D. Place of Di	00 Gc	od Hor	e Road	#919				
Ĭ.	Jor	nt of h		1 XBurial 2 🗆	Cremation 3	Removal from Si	ate N	cemetery, a It. Tal	rematory	(Name or or other plac Sant.	(8)	Date		Location - City		
thelma	Baltimore,	artme ortent injury		`4 ☐ Donation 5				Churc	Cen	etery	5 of Facility	24-06	SI	numansv	ille	, VA
1	Ba	Per Imp		Muly	- 1	bold	Qe	X	C.W.	Edwar	ds Fune	eral :	Home			
		Ф.		23a. Part1. Enter the	disease, or confailure. List only	mplications that car	used the de	ath. Do not		mode of dyin	395 Bow] g, such as card	iac or resp	Green, iratory arrest,	VA	A	Approximate nterval Between
	4	Physician .		Immediate Cause (Fi				diac	arri	1 them	195					Onset and Death
		/Medical Examiner		resulting in death)		Due to (o		equence of):		c ho	anh di	40.4				
			er	Sequentially list cond if any, leading to imm	litions, ediate	b. Due to (or		equence of):	Sre ii		- C 11.	seep			3	- yers
1	RI	cuted od ransit	Examiner	Cause (Disease or in that initiated events	jurý	C	Hra	ntonsic	n							104-5
	0,	be executed ician and burial-transi	Exa	resulting in death) La	st	Due to (or	as a cons	equence of):								
	8760,	ate hys	dicai		•	d			_						0.500	10.15.25
	9		/Me	IF FEMALE:		23c. If yes, outco	me of prec	nancy								
	Box	death e atter d for u	iciar	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐	onths?	1□Live birt 4□Pregnar	h 2∏Fe ntattimeol	etal death	3 □Ectop 5 □ Other	ic pregnancy (specify)				23d. Date of Month		ay Year
2	P.0	that the death ed by the atter detached for	Physician/Me	9 Unknown		9□ Unknow										
1 K		es ign be	by	Part II. Other signification		contributing to dea					on in Part I.	23				cause of death?
100	0.0	w requi	eted	C/6/1 3/100	1	e rice pin-i	(7 - 3		100 611		.	1 🗆 Yes	2 □ No 3 □	Probab	ly 4 🖾 Unknown
1/	Rec	has b	Completed									. 24	ta. Was an autopsy performed?	24b. Were prior death	autops to comp	y findings available letion of cause of
SHOK	Ta I			25. Was case referred	t to medical								☐Yes 2121	Vo 1 □ Y	es 20	INO
1	N.	Attending Physician: r death. sctor: After this certific by the funeral director,	o Be	examiner?		Hospital: 1 Inc	atient 2	☐ ER/Outpat	ient 3	DOA Othe	26. Place of D			6 □Other (S	2000(41)	
B	n of	ding Phys h. After this funeral di	n: T	27. Manner of Death	5 Pending	28a, Date of		28b. Time	of	28c. Injury Work			escribe how in		pecity)	
#	Siol	ttendir death. stor: Af	catic	2 Accident	investigation	on		71,01	М		res 2□No					
	Division of Vital Records,	P Sign	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	4 200. Flaue 0	Injury - At , etc. (Spec	home, farm, cify)	street, fac	tory, office		28f. Lo Cit	cation (Street ty or Town, Sta	and Number or ate)	Rural R	loute Number,
		To the Hospitel within 24 hours a To the Funeral E completely filled i	edical C	29a. Certifier 1[(Check only one) 2[☐ Certifying P ☐ Medical Exa	hysician: To the b miner: On the bas and manne	s or examir	nowledge, de nation and/or	ath occur investiga	red at the tim tion, in my op	e, date and place inion, death occ	ce, and du	e to the cause ne time, date a	(s) and manner nd place, and c	as state	ed. e cause(s)
_		To the comp	Ž	29b. Signature and titl	e of certifier					29c. License	number		29d. D	ate signed (Mo		
)		0	KNES	Alm		03	6494			6/13/		000
		4		30. Name and address Dr .	s of person who Kresai	, MD Ur	ivers	sity S		lty Ho	spital	Bal	timore,	Maryl	and	
		Sta Registr	_	31. Date filed (Month,	Day, Year) N 2 8 20		istrar's Sig	nature	rest	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Jeffrey J. Herman 06 16:35 M /Medical 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan • 23 , 1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1**X**M 2□ F 163-44-7608 54 Yrs. Director Berlin, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner and be notified at PA Beaver Director Freedom 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 113 Oakhaven Drive 15042 or Itams 23g USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ SNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene.

Is marked other than "natural, or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Drywall Insulation Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Herman Mary Kelly 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louann Herman/Wife 113 Oakhaven Drive Freedom, PA 15042 of Health itam 27 20b. Place of Disposition (Name of 20a. Method of Disposition June 30, 20c. Location - City or Town, State Department of h Important: If its any injury or of once. cemetery, crematory or other place)
Sylvania Hills Memorial Park 1 Burial 2 Cremation 3 Removal from State Rochester, PA * 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signatur of Fulleral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MONTH Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and 1635 resulting in death) Last Due to (or as a consequence of): Physician/Medical 6/24/26:0 Box IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 000 ģ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Mnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 2 No 1 ☐ Yes Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatle to the Funeral Director; ompletely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 206241 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 113.2 W.C.C. 203 INON 57 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 8 2006

Herman

FFFREY

			1 - For State Registrar	State of	Maryland / Depa		of Health a of Death			jiene _{leg. No.} 20	06	20298
	Physici	210	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Teresa M. Hicks						June	17 20	006	1506 ^M
	Examin	er	4a. Facility Name (If not institution, give s		*		vn, or Location of	of Death		4c. County		. 7 . 1
			Anne Arundel Me 5. Social Security Number 6. Sex		Center Age (In yrs. last birthday)	Anna If Under 1 Y	apolis	24 Hrs.	8. Date of Birth	Anne		
П	Funeral Director			M 247 F	85 Yrs.		ays Hours	Min.	May 31	1921	Coun D • C	lace (State or Foreign etry)
	D		Usual Residence of Decedent			L			Tree I con	1021		
	aryfar show	<u>~</u> 7	10a. State 10b. County Maryland Anne Ar	undol	10c. City, Town or Lo						10	Od. Inside City Limits
	8a-f	ecto	*	unuei	Annapo							1XCXYes 2 □ No
	with t	ă	10e. Street and Number 89 W. Washingto	n C+		10f. Zip Co	_{de} 1401			IOg. Citizen of V	√hat Coun	itry?
	leath	Funeral Director		12. Was Decede	ent Ever in U.S. 13.			gin? (Spe	cify Yes or No-	USA 14 Bace	e - Americ	an Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "netural", or ftame 23s or 28a-1 show other traumatic event, the Medical Executes frame be nuffled at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2- If Yes, Give- Year or Date	₹ ^{No}	If Yes, specify of 1 ☐ Yes 2 1 ☐ Yes	of Hispanic Ori Cuban, Mexican No Specify:		Rican, etc.)	Blac	Blac	etc.
9	2 hou		15. Decedent's Edu	ation	16a. Dece	dent's Usual O	ccupation			16b. Kind of Bu	siness/Inc	dustry
218	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use re	one during mos etired)	t of workir	ng .			
7	e filed within al Hygiene. other then vent, the Ma	Con	12th	0	Hou	sekeer				Mote1		
Ind	be fill H of other	Be	17. Father's Name (First, Middle, Last) John F. Harris							Maiden Sumam	ө)	
Maryland	should nd Mer marke	2	19a. Informant's Name/Relationship (Ty)	an Print)	10b Maili	ng Address (Ct			kell	, City or Town,	C4-4- 7'-	0-4-1
Ma	id 2 sho ith and 27 is m	4	Paulette A. Off							-		
	is 1 and 2 of Health itam 27 i		20a. Method of Disposition		20b. Place of Dispo					20c. Location -		
OE.			1 M Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	Memoria	1 Park	C (5-23	-06	Annapo	lis,	Md.
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	e MAA	483 W	Name and A	ddress of Facilit	Sons		ary, P , Md.		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cau	sed the death. Do not ent	er the mode of	dying, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	/Medical Examiner parial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	,	as a consequence of): as a consequence of): as a consequence of):	ANCE	EMBER	0613	54		61	Onset and Death N.E. MINUTE
38760,	icate be ex physician a the burial	dical										
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	1 Live birth	t at time of death 5	Ectopic pregna Other (specify				23d. Date Mor	e of deliver	ry Day Year
۵.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to deat	h but not resulting in the u	nderlying cause	given in Part I.		23e. Did tob	1		e cause of death? ably 4 □Unknown
Vital Records,	hysician: The law requires that the his certificate has been signed by th I director, page 2 should be detach	Completed							24a. Was a autops perform	y p	rior to comeath?	psy findings available apletion of cause of
ita	ian: artifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place	of Death	(Check only on		100	26.140
of <	Physician: this certific ral director,	2	1 ☐ Yes 212 No	ospital: 1 🗆 Inpe	atient 2 ER/Outpatier	t 3 DOA	Other: 4 Nu	rsing Hom	e 5 Reside	nce 6 Othe	r (Specify,)
n o	ding Ph h. After th funeral	on:	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of ! (Month,	njury 28b. Time of Injury		njury at Work?		8d. Describe ho	w injury occurre	∌d	
sio	or Attending I after death. Diractor: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	One Olean of	laines Abbama farm ou		1 ☐ Yes 2 ☐ N		06 1 10 (04			
Division	spital or Atteni ours after deatl neral Diractor; filled in by the	ertification;	4 Homicide determined	building,	Injury - At home, farm, str etc. (Specify)	eet, factory, on	ICO	2	City or Towr	reet and Numbe n, State)	r or Hurai	Houte Number,
_	Hospital 24 hours a Funeral i	O	29a. Certifier 1 Certifying Phys	icien: To the be	est of my knowledge, death	occurred at th	e time, date and	d place, a	nd due to the ca	ause(s) and mar	nner as sta	ated.
	- CV - CD	edical	(Check only 2 Medical Examination)	er: On the basis and manner	s of examination and/or in	vestigatîon, in r	ny opinion, deat	h occurre	d at the time, da	ate and place, a	nd due to	the cause(s)
	To the within 2 To tha complet	Me	296. Signature and title of certifier		, 0		ense number			9d. Date signed		
1	1			ce	- M	T	1522	45	-	JUNE	20	2006
15)		30. Name and address of person who co	mpleted cause of	of death (Item 23a) (Type,	Print)	. ^ ^		1tigh w	Λ		200C 2149 OUS MD
1~			MICHAEL L 31. Date filed (Month, Day, Year)	128	strate Signature	W) 1	16 Jet	2150	1tigh u	in /tv	nage	OLIS, MD
	Sta Registr		JUN 2 8 200	6	strar's Signature	MALL!			-	,	1	′
			JUN 4 0 E0.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26,perMD,2856,6/28/06 TT
State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June June Day **Physician** 20, 2006 2006 James Havnes 6:10 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1201 Streaker Carroll Rd. Svkesville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 237-34-8862 March 15, 1924 North Carolina Usual Residence of Decedent if flied within 72 hours after death with the Maryland I Hygiene. other than "netural", or Items 23e or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland | Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Streaker Rd. 21784 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 177Yes 2 □ No 1943-If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Supervisor Davco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental I ent: If item 27 Is marked o Henry Brownlow Havnes Jennie Mae Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree James Timothy Haynes(son) 1201 Steaker Rd. Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) June 24, 2006 Canton, NC New Cruso Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 2178/ t enter the mode of dying, such as cardiat or respiratory arrest. 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final Afherosclastic Caronay Pnysician 415 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed? 2 - No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one San a recipence Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: .4 Nursing Home 5 Residence (Specify) 1 Yes 2 No ۲ 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Roll J. Man. MO 21/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 2 8 2006

3 Registrar's Signature

			For Stete Registrar		/laryland / Dep	artment of h	Health and	d Mental Hy	Reg. No. 2 0 1	06 20300
	Physici	an	1. Decedent's Name (First, Middle, Li					2. Date of De Month		3. Time of Death 12:01 A M
	/Medic		Marvin M. Harri			4h City Town	as Location of De	June	25 20 4c. County of	
	Examin	er	4a. Facility Name (If not institution, gi Frederick Memor			4b. City, Town, o		eath	Freder	
	Funeral			Sex 7. /	Lal. Age (In yrs. last birthday	If Under 1 Year	If Under 24 H	Irs. 8. Date of Bi		9. Birthplace (State or Foreign
	Director		216-22-8858	1 X M 2□ F	79 Yrs.	Months Days	Hours M	Feb. S	ay, Year) 1927	Maryland
	, od		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland hal Hygiene od other than "neturel", or items 23a or 28e-f show event, the Medical Exacting man be profifted at	5		1	Woodbine					1 ☐ Yes 2X No
	28e-f	rect	MD Carro1	<u>T</u>	MOOGDINE	10f. Zip Code			10g. Citizen of Wh	at Country?
	aa or	<u>a</u>	7629 Newport Roa	d		21797			United S	
	death ms 2;	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or N		- American Indian,
9	after or ite		1 Never Married Married	Armed Force 1 Yes 2 [If Yes, Give	¹ N∘ 1945 +	1 ☐ Yes XXNo		ieno nican, etc.)	Specify:	White, etc.
203	urel',	d b	3 Widowed 4 Divorced	Year or Date:	s: 1946					White
21215-0036	"net	Completed by	15. Decedent's 8 (Specify only highest g		16a. Dece (Give	edent's Usual Occup is kind of work done DO NOT use retire	pation during most of a dl	working	16b. Kind of Busin	
12	withir ene. than	mc	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Driver	,		Howard W	
d 2	filed with Hygiene other thai	Be Co	17. Father's Name (First, Middle, Las	t)	TITUCK	DLIVEL	18. Mother's	Name (First, Middle	a, Maiden Sumame)	Company
Maryland	should be filed withir and Mental Hygiene. is marked other than eumatic event, I'm M	To B	George Walter Ha	rrison			Margar	et Della	Hall	
ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or	Rural Route Numb	per, City or Town, St	ate, Zip Code)
	1 and 2 Health em 27 i		Catherine Harris	on Wi		Newport		Woodbine,	,	
Baltimore,	of T		20a. Method of Disposition 1X Burial 2 □ Cremation 3	Removal from Sta	10	osition (Name of matory or other pla		ine 28,	20c. Location - Ci	ity or Town, State
Ë	. Pag tmenl tent: jury		`4 □Donation 5 □Other (Spec			prings Co	em. 2	2006	Poplar S	prings, MD
Baj	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	ensee		2. Name and Addre		neral Hom	e & Crema	tory, P.A.
			23a. Part 1 Enter the disease, or collaboration of the control of	nolications that car	and the death. Do not or	212 W O	d Libor	ty Road	e & Crema Winfield	Approximate Interval Between
68760,	/Medical Examiner bhysician and the prijal-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cause) (cause or injury that initiated events resulting in death) Last	b. Due to (or c.	as a consequence of): as a consequence of): as a consequence of):	The Gay	410003		1130476	Gears
P.O. Box 6	The law requires that the death certificate be existence in the has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 ☐ Fetal death 3 tat time of death 5	□Ectopic pregnand □ Other <i>(specity)</i> _	y		23d. Date (Month	,
	s that ned b e deta	by Pi	Part II. Other significant conditions	_ ^				23e. Did	tobacco use contrib	ute to the cause of death?
Records,	w require been sig should b	ed b	798	1 019	abates m	DUC19 h	ς	_ 1 🗆	Yes 2 □No 3	Probably 4 Unknown
000	law requass been 2 should	piet						24a. Was		ere autopsy findings available or to completion of cause of
Ä	The ate ha	Completed						perf 1 ☐ Yes	ormed? dea	ath?]Yes 2□ No
Vital	cien: ertific sctor,	Be	25. Was case referred to medical examiner?	Hospital:			han	Death (Check only		
of	Physi this c al dire	10	1 Tes 2 No	Hospital: 1 Inp		THE SELECT			idence 6 Other	
n C	After funer	lo	1 Natural 5 Pending	(Month,	Day Year) Injury	Wo	rk? Yes 2 🗆 No	Zod. Describe	now injury occurred	•
Division	l or Attending Physicien: after death. Director: After this certifics in by the funeral director, I	Certification:	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At home, farm, s etc. (Specify)				(Street and Number own, State)	or Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C			est of my knowledge, dea s of examination and/or i stated.					
	To the within To the comp	Σ	29b. Signature and title of confiler	100	KID.	29c. Licen	se number		29d. Date signed (
	6X1		30. Name and address of person who Ronald E. Mille:		of death (Item 23a) (Type 4 Culwell		O Roy ?	10 M+ 4	liry MD	21771
	St	ate	31. Date filed (Month, Day, Year)		istrar's Signature	DITAG' L	O DOX Z	10, Pil. F	TTA' IM	41//1
	Regist		11111 0 0 00	00	4 1	and I				
DI	HMH 17 Rev 1/2	2001	JUN 2 8 20	UO JUNE	w & Ap					
					ORIGIN	AL				

			For State Registrar		State of	Marylan		artment o			Mental Hy	giene	006	20301
	Dhariai	No.	1. Decedent's Name (First,	Middle, La	ast)				_		2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Clementine			М.		Jao	ckson		06	26	2006	1:57a. ^M
	Examir	ner	4a. Facility Name (If not ins			ber)			wn, or Locat		th	4c. Co	unty of Death	
		in the	Joseph Ricl						timor					
	Funeral Director		5. Social Security Number 218-18-70 Usual Residence of Deced	58	Sex 7 1□M 2KQF	. Age (In yrs. 84	Yrs.		Year If Ur Days Hou			ay, Year)	Coun	lace (State or Foreign htry) MD
	and and		10a. State 10b. C			10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary 1 ehr	to	MD	NA		В	altim	ore						Yes 2 No
	death with the Maryland ma 23a or 28a-1 show r must be notified at	irec	10e. Street and Number			1		10f. Zip Co	ode			10g. Citizer	of What Coun	ntry?
	th with	ai D	3228 Gwynn	s Fa	lls Par	k wa y			2121	6		U	.S.A.	
	r dea	Funeral Director	11. Marital Status		12. Was Deced Armed Ford	ent Ever in U.	S. 13.	Was Deceden	t of Hispanio	Origin? (Specify Yes or No to Rican, etc.)	o- 14.	Race - Americ Black, White,	
36	hours after death v tural', or itema 23s	by Fu	1 ☐ Never Married 2[3 X Widowed 4 ☐ Div		1 ☐ Yes 2 If Yes, Give			1 □ Yes X					ecify: Bla	
21215-0036	ž 3 3			cedent's E	Year or Dat	es:	16a Dece	dent's Usual C	Occupation				of Business/Inc	
7.	nin 72 n nai	piet	(Specify only Elementary/Secondary (highest gr	rade completed)	lor F . \	(Give	kind of work of DO NOT use i	done during retired)	most of wo	orking		wood 3	
212	d withi giene. er then	Completed	12th grade	J- 12)	College (1-4 na	+01 5+)	H	ealth	Aide			Hosp	ital	
	2 should be filed with and Mental Hygiene, is marked other than aumatic event, Inn.	Be	17. Father's Name (First, M	liddle, Las	t)						me (First, Middle			
SAB	should ind Meni	ပ္	Harry Conl	_							lice C			
/S7 Maryland	s 1 and 2 should be filed within 7 if Health and Mental Hygiene. item 27 is marked other than "n other traumatic event, the Med		19a. Informant's Name/Re Herman For			phew	19b. Mailir	ng Address (S 5 Car	treet and Nu riage	mberorA H il	ural Route Numb	er, City or To Laur	el, Mo	^{Code)} d 20707
	of Health of Hea		20a. Method of Disposition	C DO11	01. 110	_		sition (Name natory or othe	_	1	Date		ion - City or To	
/o6 nore	ages ent of nt: if i		1X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot							6/30	/2006			le, Md
るら(06 Baltimore,	permit. Pages Department of I Important: if its eny injury or o		21. Signature / Funeral S		4	OL.		Name and A						
_	88 5 8		Mann	on	Mak	am	43	00 Wa	bash	Ave	Balti	more,	Md :	21215
9			23a. Part1. Enter the diseashock, or heart failure	ase, or con e. List only	nplications that car y one cause on ear	used the death ch line.	n. Do not ent	er the mode o	of dying, such	as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		_a. N	netas	tatic	600	n_Ca	ncel	-		n	Onset and Death
	/Medical Examiner		resulting in death)	•	Due to (o	r as a consequ	uence of):							
		-E	Sequentially list conditions		b. — Due to fo	as a consequ	uence off							
J	uted 1 ansit	Examiner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	` ~	,	,	,							
20	ate be executed hysician and the burial-transit	Еха	that initiated events resulting in death) Last		C. Due to (or	r as a consequ	uence of):							
9760	ate be ex thysician the buria	dical		- (d									
500	artifica ing ph a as t	Med	IF FEMALE:									1		
Box	leath certifica attending pl f for use as t	lan/	23b. Was decedent pregna in the past 12 months			h 2 Fetal	death 3	Ectopic pregr				23d.	Date of delive Month	ny Day Year
<u>ੂਟ</u> ਨੂੰ	requires that the death certific een signed by the attending p hould be detached for use as	Completed by Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∐Pregnar 9☐Unknov	nt at time of de m	eath 5L	Other (speci	fy)					31,
٦, ٩.	that the do	'Ph	Part II. Other significant co	onditions	contributing to dea	th but not rest	ulting in the u	nderlying caus	se given in P	arti.	23e. Did 1	obacco use	contribute to the	e cause of death?
ာ ဥာ	w requires that been signed E should be deta	Q P									1 🗆	Yes 2 □ N	o 3 Proba	ably 4 Unknown
- ne	> 0 0	olete									24a. Was		4b. Were autop	osy findings available
A R	9 - 9	E									auto perfo	psy ormed?	prior to con death? 1 \(\sum \) Yes	rpletion of cause of
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to mexaminer?	nedical					26. P	lace of De	ath (Check only	-	10,163	. 1
2 Z S	G : S	5	1 Yes 2 No		1		ER/Outpatien	t 3 DOA	Other: 4	Nursing I	Home 5 ☐ Resi	dence 6,2	Other (Specify	Hospice
	ding Ph h. After th funeral	5		ending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work?	-	28d. Describe	how injury or	curred	
	Attending r death.	cat	E C 7 TOO I GOTT	nvestigatio Could not t	ne	A Laivas - At ha		М	1 ☐ Yes 2	No □	00/ 1			
C/e /	ior A after Direction by	Certification:	4 Homicide	determined	building	f Injury - At ho g, etc. <i>(Specif</i>)	nne, rarm, str	eet, ractory, o	TICE		City or To	wn, State)	umber or Hurai	Route Number,
	lospitai hours a 'unaral C		29a. Certifier 12 Ce	rtifying P	hysician: To the b	est of my kno	wledge, death	occurred at t	he time, date	and place	e, and due to the	cause(s) and	i manner as sta	ated.
	T 4 T 2	ledicai	(Check only 2 Me	dical Exa	miner: On the bas and manne	is of examination of stated.	tion and/or in	estigation, in	my opinion,	death occ	urred at the time,	date and pla	ce, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and tale of	ertifier					icense numb		0		gned (Month, E	
			- Cla	WD					241			Jun	e 26, 2	2006
	5		30. Name and address of p	0.	1	of death (Item	23a) (Type,	Print)	C+ 12	. 16:	nose pl	D Di	201	
	Sta	te	31. Date filed (Month, Day,	10.0	ney +650	gistrar's Signa	ture	- wiaw	2.1 13	alti	ruis pr	V LI	201	
	Registr	- 1	JUN 2	8 2008		J. J.	Span							
			771173		The state of the s		1							

Amend item#23a,pen*ID, 6356,6/28/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician CATHERINE 2006 2:00 A M 25 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore City

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. University of Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Sirth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖵 F Director 220-03-5469 90 29,1915 Maryland Usual Residence of Decedent 10a, State 10h County 10c, City, Town or Location 10d, Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Essex Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Handsworth Place Apt. D 21221 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥1Yes 2□No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Martin Marietta 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be tem 27 is marked of ္ရ Elmer Parker Teresa Bream 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline M. McHone (Friend) 24 Freedom Court Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MD Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem, 6/29/2006 Baltimore, Maryland 21. Signators of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failere. List only one cause on each lipe. Cardiac arrhythmia Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Linchre disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed pean 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate yperlip 1 ☐ Yes 2 Ø No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 1 Yes 2€No 2 ER/Outpatient 3X DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 Tyes 2 No investigation Director; / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dirs 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD XIANGRONES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3400 Loch Paver 31. Date filed (Month, Day, Year) 32. Acistrar's Signature State JUN 2 8 2006 Registrar

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			_ State	State of Mary		partment of F ertificate of I				20303
			Registrar 1. Decedent's Neme (First, Middle, Last)			Crimoato or i	Douth	2. Date of Death	. No.	3. Time of Death
	Physicia		Irene Marta	Krawcz	zyk			June :	Day Yeer	6642 AM
)	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)			Location of Death		4c. County of Dec	oth
			Union Memorial	-		Baltim			n/a	
	Funeral Director		1/0-24-1/33	м 2 Б F 7. Age (Ir	yrs. last birthd	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 22, 1	9. Bi 9 30 Ma	nhplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryli f eho	ō	Md. Baltim	ore	Dune	dalk				1 ☐ Yes 2X No
	r 28a	Irec	10e. Street and Number	010	Dun	10f. Zip Code		100	. Citizen of What C	ountry?
	th with	alD	815 Loalan Aven	ue		2122	2.2		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic evant, the Medical Exameration in allied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Eve Armed Forces? 1 [] Yes 2 [XNo If Yes, Give	r in U.S.	 Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☒ No 	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: [L1]	
21215-0036	hour fural	ed b	15. Decedent's Educ	Year or Dates:	16a. De	cedent's Usual Occup	ation	16	b. Kind of Business	
15	n na n na	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(G	ive kind of work done on DO NOT use retired	during most of work	ing		,
212	filed withi Hygiene. Other than	E O	Elementary/Secondary (0-12) 12th	4 yrs.	Drug	g & Alcoh	ol Coun	selor	City of	Baltimore
	e filed al Hygid d other	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
yla	and Mental is marked of aumatic evi	9		ngbar				naszews		
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Typ							
e)	1 and Health em 27		Casimir C. Kraw 20a, Method of Disposition		20b. Place of Di	5 Loalan sposition (Name of			c. Location - City o	
<u>o</u>	ages ant of it: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, d Bayviet	crematory or other place W Cremato	ry 6-24	-2006 B	altimor	e, Md.
Baltimore,	permit. Pages 1 and Department of Healti Important: If Item 27 any injury or other 1 once.		21. Signature of Funeral Service License	•						al Home, PA
			23a. art1. Enter the disease, or complic	cations that caused the		1201 Dun \dot{c}				Approximate
	Physician		shock, or hear failure. List only one Immediate Cause (Final disease or condition	V-FIB						Interval Between Onset and Death 2 MINNEC
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		- 1			10
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	on uence of):	Ny are	edal nosis			10 years
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that injured events.	Renal	arte	Vu Ste	212 on			5 years
o,	eath certificate be executed attending physician and for use as the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):)				
68760,	ate be hysici the bu	edical	d.							
_	certific ading pl	/Mec	IF FEMALE:	le If use outcome of s						
Box	death o	Physiclan/M	in the past 12 months?	3c. If yes, outcome of p 1 Live birth 2 4 4 Pregnant at tim	Fetal death	3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of de Month	Day Year
0	y the	ysic	1 Tes 25 No 9 Tunknown	9 Unknown	o or doub!	o _ o.i.io. (apoony)				
ο.	w requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions con-	tributing to death but n	ot resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rds	een sign	ed b						1 ☐ Yes	2 □ No 3 □ F	robably Inknown
Records,	2 55	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ä	Th ate pag	Com						performe 1 ☐ Yes 2 ☐	d? death?	s 2 No
Vital	ysician: The	Be	25. Was case referred to medical examiner?	accital: AA		Oth		h (Check only one)		
of	shys this	. To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpa 28b. Tim	tient 3 DOA	4 Nursing Ho	me 5 TResident 28d. Describe how	be 6 Other (Spe	ecify)
O	ding fh. After funer	tlon	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	eer) Inju	ry Wor	k? Yes 2 ☐ No	200. 200000		
Division	Attending r death.	Certification:	3 ☐ Suicide 6 ☐ Could not be			street, lactory, office		281. Location (Stre	et and Number or F	lural Route Number,
D	al or	Serti	4 Homicide determined	building, etc. (5	Specify)			City or Town,	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (ician: To the best of mer: On the basis of ex and manner stated	amination and/o					
	To the To the To the To the Somple	Me	29b. Signature and title of certifier			29c. Licens	e number	290	I. Date signed (Mor	th, Day, Year)
	_			nn		AT	242529	46:	June 23	2006
	7		30. Name and address of person who con	mpleted cause of deat			- , ,	()	1011	
	0.		marita MIKE	MD		on Memor	nal ho	Spital		
	Sta Regist		31. Date liled (Month, Day, Year)	32 Registrar's	Signature	park		•		

DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar	State o	f Marylan		artment of <i>tificate of</i>	Health and I Death		giene) Reg. No.	006	20	304
				Decedent's Name (First, Middle, La	ist)		-		,	2. Date of De	ath		3. Time	of Death
		Physici /Medic		MILDRED EVELYN KOWA	LEWSKI					JUNE 26	Day 2006	Year	7:35	A M
		Examin		4a. Fecility Name (If not institution, given	e street and nui	mber)		4b. City, Town,	or Location of Deat			unty of Death	1	
				BALTIMORE WASHINGTO	N MEDICAL	CENTER		GLEN BUR	NIF		ANN	IE ARUNDI	FI	
		Funeral		5. Social Security Number 6. 5	Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r ff Under 24 Hrs.	8. Date of Birt	th	9. Births	place (State	or Foreign
		Director		003.16.1548	1□M 2\d F	78	Yrs.	Months Days	Hours Min.	(Month, Da FEB 15,		Coui	ntry) NH	
	P			Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1020		111.	
	rylar	e how		10a. State 10b. County		10c. City	y, Town or Lo	cation					IOd. Inside	City Limits
	₩	- 4	ç	MD ANNE ARUI	NDEL	GLEN	N BURNIE						1	s 2 No
-	th th	or 28	ë	10e. Street and Number	2.5.5			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
~	death with the Maryland	238	ai	617 ELIZABETH RD				21061				USA		
Kowalewsk	dea	e E	Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13. \	Vas Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	- 14.	Race - Americ		
0)	5-0036 72 hours after	or it	F	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv			Yes 2 No		io nican, etc.)		Black, White,	etc.	
*		Exe	d by	3 Widowed 4 Divorced	Year or D	ates:		XX	Specily:		Spe	ec <i>ify:</i> WHI	TE	
D	5-C	dical	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Deced	lent's Usual Occu	pation	rkina	16b. Kind o	of Business/In		
\preceq	within	e le le le le le le le le le le le le le	du	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life. L	OO NOT use retire	ed) most of wor	9				
2	d 21	ygier tr	ပ္ပ	12			QUALI	TY ASSURAN	ICE		INS	SURANCE		
_	ind ind	d ot	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sun	name)		
-	should	Men arke	မ	JACOB SHEPTOR					unk					
Mildred	lar 2 sh	and le m	0.1	19a. Informant's Name/Relationship (Турө, Print)		19b. Mailin	g Address (Stree	at and Number or Ru	ıral Route Numbe	er, City or To	wn, State, Zip	Code)	
-	and bue	n 27 n 27 ier tr		EDWARD KOWALEWSKI	HUSBA		617	ELIZABETH	RD GLEN BUR	NIE, MD 2	1061			
	ore es 1	r of H		20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐	Domount from		lace of Disposemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location	on - City or To	wn, State	
-	Pag Pag	int: I		4 □ Donation 5 □ Other (Special		State		CEMETERY		.2006	CROWNS	/ILLE M	D	
>	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at	Department of Heelth and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Iteme 23e or 28e-f ehov eny Injury or other traumatic event, the Medical Examinar must be notified at ORGE.		21. Signature—Funeral Service Lice	699	0	2	Name and Addr	ess of Facility		ONOMINO	rees, n		
	m g	eny l		CREGORY FINK	U+-	M0114	8 426	NK FUNERAL 5 CRAIN HW	HOME, P.A. Y SW GLEN B	URNIE MD	21061			
				23a. Part1. Enter the disease, or comshock, or heert failure. List only	pications that c		n. Do not ente	or the mode of dy	ing, such as cardiac	or respiratory ag	rest,		Approxima	
	Dh	nysician		Immediate Cause (Final	Office Cause Diffe	ach liner	nu		V 1	where to	in		Onset and	Death/
		Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	or as a consequ	Jenon of VI	('ara	1	960 011			10 011	NUHI
	Ex	kaminer			OA	Make	A CONTRACTOR	Dru.	1/1400	14			8 160	20.1
		3	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of):	Jer -	0,00			1	J 9 4	41
	pet.	insi T	Examiner	Cause (Disease or injury	,			1					,	
) SXBCI	al-tran	xa	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):				-			
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	pspil	hour inere		29a. Certifier 1 Certifying Ph	ysician: To the	best of my know	viedge, death	occurred at the ti	ime, date and place,	and due to the c	ause(s) and	manner as st	ated.	
	Ĭ	n 24 ne Fu	edical	(Check only 2 Medical Exer	niner: On the ba and mann	isis of examinati	ion and/or inv	estigation, in my	opinion, death occur	rred at the time, o	late and plac	e, and due to	the cause(5)
	Tota	within 24 hours after of To the Funerel Direct completely filled in by	M	29b. Signature and title of pertifier	111	,		29c. Licens	se number	2	9d. Date s	ned (Mopth, L	Day, Year)	
				EN PONT	or Vill	2			1)2009	74	6/2	6/01		
		10		30. Name and address person who,	completed aus	of death (Item	23a) (Tyne #	Print)	1. 1	11	nt	0-12	,	,
		Y		Elliet workal	1 000	1411	Mad	10 Par	K Drive	bren	DUST	11P. 140	1. 211	06/
	441 4	Sta	te	31. Date filed (Month, Day, Year)	457	egistrar's Signar	ure	R)		1 / (1	1	4
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State of Maryland / Department of Health and Mental Hygien P 1 1 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician emon 4a. Facility Name (If not institution, give street and number) June 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hospital Bultimore MOVE City Year If Under 24 Hrs. HOOKIAS Social Security Number Age (In yrs, last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F Months Days Hours Min 57 Director 219-50-1975 AUG 23 1948 MARYLAND Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2304 WINCHESTER ST. APT B. Funeral 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXYes 2 □ No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates: 67/69 Be Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade LETTER CARRIER US POSTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS J. LEMON SR. JANIE HUGGINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Lemon Jr./Son 6219 McClean Blvd, Baltimore, Maryland 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST 06-29-06 OWINGS MILLS, MARYLAND 21. Signature of Fund al Service Oceans 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Store the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Widely **Physician** metastatic Non-small years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the ate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1☐Yes 2X No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UCHENNA OKAGBUE, The Johns Hopkins Hospital , 600 North Wolfe Street Baltimore. Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 28 2006 Registrar

	PI / E
ds, P.O. Box 68760,	n: The law requires that the death certificate be executed
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Division	he Hospitel or Attending Physicien

	For State	• •	l / Depar	tment of Health and M ficate of Death	lental Hygie	2006	20306
	Registrar 1. Decedent's Name (First, Middle, Last)		OGILI	neate of Death	2. Date of Death	. No.	3. Time of Death
Physician /Medical	Hazel Maude Leach				_ Month _	5 2006	8:25 A ^M
Examiner	4a. Facility Name (If not institution, give		4	b. City, Town, or Location of Death		4c. County of Death	1
	VA Maryland Health	<u>-</u>		Perry Point		Cecil	
Funeral Director	504-20-1444	7. Age (In yrs. last		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 07/18/19	ear) Cou	pplace (State or Foreign untry) uth Dakota
pur *	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	tion			10d. Inside City Limits
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vith the Maryland to 286-1 show be neithful at	10e. Street and Number	NIC NII	11957111	10f. Zip Code	100	. Citizen of What Cou	untry?
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r Items 23s	12335 Harford Roa	12. Was Decedent Ever in U.S.	. 13. Wa	21087 s Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A. 14. Race - Amer	
if a start of the	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No			Hican, etc.)	Black, White	, etc.
<u>و</u> ا	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW I]Yes 2M∏ No Specify:		Specify: Wh	ite
ed within 72 hours ygiene. ner then "neturel", t, the Medical Exe t, completed by	15. Decedent's Edu (Specify only highest grade		(Give kir	nt's Usual Occupation and of work done during most of work	ing 16	b. Kind of Business/l	ndustry
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d 2 should be th and Mental if is marked treumatic ev	Frank Morrison 19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing	Anna Ma Address (Street and Number or Rura	ude Kess] al Route Number. C		ip Code)
and 2 seath and 2 seath and 2 seath and 27 is				Harford Road - 1			
- I = -	20a. Method of Disposition	20b. Pla	ce of Disposit	ion (Name of		c. Location - City or 1	
Pages nent of int: If it	1 Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•	tory or other place) 11ev Mem. 06/2	0/2006		
artm. Forter orter injur	21. Signature of Funeral Service Licens		22. N	Name and Address of Facility E.	9/2006 1	imonium,	Maryland
permit Depar Impor any in	1 E A X	assaln	1117	50 Belair Road -	Kingsvil	le Maryl	and 21087
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Physician	Immediate Cause (Final disease or condition	Lung Cancer					Onset and Death Unknown
/Medical	resulting in death)	Due to (or as a conseque	ence of):				OHKHOWH
Examiner	Sequentially list conditions,	0.					
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le be executed ysician and e burial-transit cal Examit		Due to (or as a conseque	51100 01).				
0 % 0		d					
leath certificate attending phy	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance				23d. Date of deliv	verv
death a atter d for u	in the past 12 months?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		ctopic pregnancy Other (specify)		Month	Day Year
by the attached	9 Unknown	9□ Unknown					
The law requires that the death certifical are has been signed by the attending phypage 2 should be detached for use as the completed by Physician/Medicanty	Part II. Other significant conditions con	ntributing to death but not result	ting in the und	erlying cause given in Part I.	23e. Did toba	cco use contribute to	
w require been sig should b	Chronic Obstructi	ve Pulmonary D	isease		1 🗆 Yes	2 □No 3 □ Pro	bably 4 Hunknown
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ing P	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	28d. Describe how	injury occurred	
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tel or Attending P rs after death. al Diractor: After t ed in by the funera	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		t, ractory, office	City or Town, S	State)	arriodie Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be 6	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinational manner stated.	rledge, death on and/or inve	ccurred at the time, date and place, stigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
ithin ithe or the comple	29b. Signature and title of certifier	una mannor stated.		29c. License number	29d	Date signed (Month	, Day, Year)
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1	30. Name and address of person who co	1	23a) (Type, Pr		20	7 23/00	
-7'	Jianyi Zhang, MD			Care System Perr	y Point,	MD 21902	
State	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ıre 🚁				
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DHMH 17 Rev 1/2001

Registrar

State

31. Date filed (Month, D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:35 June 20, 2006 Linton Wayne /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick College View Nursing Home Frederick Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Mar. 28 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 10 M 2□F Months 1910 Virginia 96 Director 227-03-4803 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location rithen "natural", or items 23a or 28a-f ehow the Medical Examinar must be rigitled at 1 ☐ Yes 2 🛮 No VA Manassas Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10214 Balls Ford Road 20109 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after toppartment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or item eny injury or other treumatic event, the Manical Exempt 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ White 3 ⊠Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Blain Linton Addie E. Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 44 South Loudoun St., Lovettsville, VA Grace Hummer (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State Stonewall Memory Gdns. 6/24/06 Manassas, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Price Funeral Home 9609 Center Street Manassas, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C ARDIOMY OPATHY 5 YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) the attending physiclen hed for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h Time of After Certification: Hospital or Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No М 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Func (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/21/06 D21936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BJC THOMAS JOHNSON DR. FREDERICK A. Donkerson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 20309 For State Registra Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician June 18 2006 1440 Elizabeth Ann Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs. Months Days Hours Min. June 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) , Funeral 1914 Maryland Months 1 ☐ M 212 F 92 Yrs. June Director 218-20-0924 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Directo Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20743 602 64th Place USA Herns 23a death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural" once any injury or other traumatic events. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Housewife N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Smith Mary Berry ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Pinkney(Son) 602 64th Place Seat Pleasant, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem 6-24-06 Clinton, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Eachling Wm. Reese & Sons Mortuary, Zavry D. Keese MOOY83 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10m disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Secuentially list our littons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence burial-transit or Attending Physician: The law requires that the death certificate be executed Exam nding physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ate has been signed by t page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this To the Funeral Director: After th completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 Yes 2 No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical and the of certifier .29c. License number 29d. Date/signed Month, Day, Year, 29b. Signature 2006 as u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENNSY luania Ave. S.E. washington Busch 60 YELER 6 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 8 2006

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	-	10	Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of L	Jeani	2. Date of De	Reg. No:-		3. Time of I	Death
	Physicia		Darlene M. Lawson	1				June	25, 20	006	11:21	ΡМ
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of De		4c. County			
п			Kline Hospice Hou	ise		Mt. Air	-		Free	deric		
	Funeral Director		212-64-7799	7. Age (In yrs. Ia.		If Under 1 Year Months Days	If Under 24 H Hours M		v. Year)	9. Birthp Coun Penn	lace (State or try) sylvan	Foreign ia
	tand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside Cit	y Limits
	Mary -f sh	tor	MD Frederic	k Lib	ertyt	OWD					1 ☐ Yes	2 XNo
	or 286	irec	10e. Street and Number		010)0	10f. Zip Code			10g. Citizen of V	What Coun	try?	
	ath wi	rai	11920 Main Street			2176			United			
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, Its Maxical Examinat rout to indiffice a page.	Funerai Director	1 Never Married Married	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give 		Vas Decedent of His f Yes, specify Cubar I □ Yes 2X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Specify	e - Americ ck, White,	etc.	
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21215-0036	n 72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	urina most of v	vorking	16b. Kind of Bu	usiness/Ind	lustry	
712	iene. iene. rthen	отр	Elementary/Secondary (0-12)	College (1-4or 5+)		keeper			Mel-Ju	ıle		
פ	at Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	Maiden Suman	18)		
Vlar	Menta Menta arked	To	Carl Rizzo				Maxine	e Rizzo				
Maryland	2 sho		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ig Address (Street a			7-2-2-1			100000000000000000000000000000000000000
e,	1 and Health em 27 ther t		Sal J. Costantino 20a. Method of Disposition			O Main St sition (Name of	. P.O.	Box 508	Liberty 20c. Location	City or To	MD 2	1762
nor	ages int of t; If it		1 Durial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State cer	metery, cren	natory or other place	· Ju	ne 29,				
Baltimore,	nit. Partme ortan injur.		21. Lignature of Funeral Service Acer		22	ove Cemete Name and Address	s of Facility	2006	Mt. Air	22.5		
ä	Departing Department of the partment of the pa		Lay OC	any	B	urrier-Qu 212 W. Ol	een Fur d Liber	neral Hom ctv Road	e & Cren Winfiel	nator Id M	X,Pið	84
		1	23a. Part I. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not ente	er the mode of dying	, such as card	iac or respiratory a	rrest,		Approximate Interval Betw	veen
	Physician	(Imme jate Cause (Final disea e or condition a.	END STA	GE R	LONDE FA	916026	E			Onset and D	
	/Medical Examiner			Due to (or as a conseque	ence of):							
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	ansit A	Examiner	Cause (Disease or injury that initiated events									
oʻ	ficate be executed graphsician and its the burial-transit	Еха	resulting in death) Last	Due to (or as a conseque	ence of):							
8760,	ate be hysici the bu	dicai	d.									
9	ding b	/Med	IF FEMALE:	c. If yes, outcome of pregnan	cv				204 0-4			
Вох	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 55 No	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			Mo	te of delive Inth	•	ear
O.		hysi	9 Unknown	9□ Unknown								
S, D	res tha igned l be det	by P	Part II. Other significant conditions conf	ributing to death but not result	ting in the ur	ndertying cause give	n in Part I.	23e. Did t	obacco use cont			
ord	v requir been si should I							- 10'	Yes 2□No	3 Prob	abiy 4)∕ ⊡Ui	nknown
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of V	Physician: r this certific ral director,	ToE	1 1 462 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		R/Outpatien		4 PHOUSING	Home 5 ☐ Resi	dence 6 Oth	er (Specify)	
o u	ding P. h. After t funera		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	now injury occurr	red		
Division	Attending r death. ector: Afte by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne. farm. str		′es 2 □ No	28f. Location (Street and Numb	er or Rura	Route Numb	00 <i>r</i> .
<u>S</u>	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)		,		City or To	vn, State)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier (Check only one) 1 **Z* Certifying Phys 2 ** Medical Examin	er: On the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ice, and due to the courred at the time,	cause(s) and ma date and place, a	inner as stand due to	ated. the cause(s)	
-	To the within To the comp	M	29b. Signature and title of certifier	V		29c. License			29d. Date signed			
				1 00		D3	32171		6/:	27/0	G	
	10		30. Name and address of person who cou			Print) 328 WAI	LKERSU	ILLE MD	21793			
6.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re			,				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] [Amend Items 3,26 per Dr., G856 96 428 196 dipeath 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:50p. [™] LYNN HARVEY McNEILL, SR. Jun 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**☆**M 2□F Yrs. 217-70-2383 46 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Medical Examiner must be notified at **BALTIMORE** 1XYes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3440 ELMORA AVENUE 236 21213 U.S.A deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "naturel", permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natureny injury or other treumatic successions." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **PURIFICATION OF WATER** TRUCK DRIVER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **NEAL McNEILL** SONJA LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEAL McNEILL Father 2231 ASQUITH STREET BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State

1 □ Dopation 5 □ Other (Specify) 06/10/06 BALTIMORE, MD TRINTY CEMETERY 21. Signature of uners 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 23a. Part1. Enter that disease shock, or heart failure Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final) Physician 1645 disease or condition resulting in death) /Medical Due to (or s a consequence of): piratery distress Syndrene Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit 300 attending physician and that initiated events resulting in death) Last Due to (or as a consequar ce of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death detached Division of Vital Records, P.O. 9 Unknown 9 🗍 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 2 No To the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 THomicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier **RES-000** June 17, 2006 32. Regtstrar's Signature 31. Date filed (Month, Day, Year) State JUN 282008 Registrar

Replyement

Michael William Mulcahy

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 20312

Director 145-36-7549 1x M 2 F 58 Yrs. Months Days Hours Min. October 2, Usual Residence of Decedent 10a. State 10b. County MD Montgomery Gaithersburg 10c. City, Town or Location Gaithersburg 10c. Street and Number 10c. Street and Numb	4c. County of Death Montgomery M/DD/YYYY) 9. 8 irthplace (State or Foreign Country) N.J. 1947 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country?
4a. Facility Name (if not institution, give street and number) 776 Quince Orchard Boulevard T2 5. Social Security Number 145–36–7549 Usual Residence of Decedent 10a. State 10b. County 4b. City, Town, or Location of Death Gaithersburg 4b. City, Town, or Location of Death Gaithersburg 7. Age (In yrs. last birthday) 15. Social Security Number 145–36–7549 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	4c. County of Death Montgomery 1947 9. 8irthplace (State or Foreign Country) N. J. 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country? A. 14. Race - American Indian, 8lack,
776 Quince Orchard Boulevard T2 Gaithersburg 5. Social Security Number 145–36–7549 Usual Residence of Decedent 10a. State 10b. County Gaithersburg Funder 1 Year If Under 24Hrs. Months Days Hours Min. October 2,	Montgomery 1947 9. 8 irithplace (State or Foreign Country) N. J. 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country? A.
Director 145-36-7549 1 Months Days Hours Min. October 2, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Months Days Hours Min. October 2, October 2, October 2, October 3, October 3, October 4, October 4, October 5, October 5, October 6, October 6, October 7, October 6, October 7, Octobe	1947 Foreign Country) N. J. 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country? A. 14. Race - American Indian, 8lack,
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i MD M.	Citizen of What Country? • A • 14. Race - American Indian, 8lack,
The first part of the part of	Citizen of What Country? • A • 14. Race - American Indian, 8lack,
776 Quince Orchard Place 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced Iryes, Give Year 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Decedent's Education (Specify only highest grade completed) 1 Security of the particular of Hispanic Origin? (Specify Yes or No-lift Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify:	.A. 14. Race - American Indian, 8lack,
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College (1-4 or 5+)	
15. Decedent's Education (specify only highest grade completed) 16. Decedent's Education (specify only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid 19. Decedent's Education (specify only highest grade completed) 19. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 19. Repair Air Conditioner 19. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 19. Meaning Maid and Maid 19. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 19. Meaning Maid and Maid 19. Mailing Address (Street and Number or Rural Route Number) 19. Mailing Address (Street and Number or Rural Route Number)	ir Condition
18.Mother's Name (First, Middle, Maid Fig. 19 19 19 19 19 19 19 19 19 19 19 19 19	en Surname)
To be a second s	City or Town State Zin Code)
The part of the pa	
John Mulcahy/ Brother 11620 Moorestown Place, Gaithersburg, I 20a. Method of Disposition (Name of cemetery, I Removal from State crematory or other place)	c. Location - City or Town, State
The surial 2 X Cremation 3 Removal from State Crematory or other place) E 2 3 5 1 4 5 1 1 8 urial 2 X Cremation 3 Removal from State Crematory or other place) Chesapeake Crematory 06/28/2006 Box	eltsville, MD
20a. Method of Disposition 1 8urial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 22c. Name and Address of Facility remation Fund Steven H. Williams MCCOS6 (por DVR) 27c. Name and Address of Facility remation Fund 27c. Name and Address of Facility remation Fund 27c. Name and Address of Facility remation Prince 27c. Name and Address	e Alternatives
Steven H. Williams, Mu0980 (per DVR) 8/1/ Green Pastures Drive Baltimore	
Physician /Medical 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sfailure. List only one cause on each line.	shock, or heart Approximate Interval Between Onset and
Examiner Immediate Cause (Final disease a. Chronic Obstructive Pulmonary Disease	Death
b	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
d.	
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O9 25 UNPENDED X AMENDED IVEIH/21, perrn, 0807, //1//00 11 We use the property of the propert	23d Date of delivery
X General Section Control of the Con	Month Day Year
past 12 months? 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc	co use contribute to the cause of death?
Sping and prints 2	No 3 Probably 4 Unknown
The law require figure has been significate has been significate has been significate has been significate has been significate has been significated by the property of the	24b. Were autopsy findings available prior to completion of cause of death?
The state of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	N 1 Yes 2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Resi	
The spiral of th	
Use 2 No	njury occurred
The state of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury	t and Number or Rural Route Number, City
To be a light of the control of the	
0.50	d. Date signed (Month, Day, Year) Ine 21, 2006
30. Name and address of person who completed cause of death (Item 23a)	
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 2006 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#4c,perMD (356,6/28/06 TT
State of Maryland / Department of Health and Mental Hygiene 2 () () () 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month # Days Hours Min. 12/18/ N/A 4c. County of Death COIDA Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 F 191-26-4554 71 Pennsylvania Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 Yes 2 □ No Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 6737 Bessemer Ave. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Warakomski Walter Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. Baltimore, Md. 21222 Mr. Chester Michalski 6737 Bessemer 20b. Place of Disposition (Name of Saconetes) cranation of the rojace) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/06 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mary Cemetery Kaczorowskifackuneral Home P. A. 21. Signature of Funeral Se Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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pernit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelih and Menial Hygiene I be partment of Heelih and Menial Hygiene I mortant: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, II a Medical Examinar mast ke notified at ones.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

/Medical

Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Certification; To

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

1 Yes 2 No 3 Probably 4 2 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death | Check only one)

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

and address of person who completed cause of death (Item 23a) (Type, Print) BINKUN

State Registrar

Medical

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. Day 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12 30 AM 2006 Donnel 20015 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltymore Perring Center Tarleville Genesis Ta way If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6 Sex **Funeral** 1□M 2**X**F Days Hours Min. 01°09°1918 Maryland 88 216-07-9865 Yrs. Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or freme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event, the Medical Examinar must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDN/A Funeral Director Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3014 Harview Ave 2nd Floor 21234 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Wooton Marie Bazic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald D. O'Donnell/son 3014 Harview Ave 2nd Floor Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 06-27-2006 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice CAPA Stêphen D. Lohrmann PA 8717 Greenpastures Dr. Towson MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endstage Alzhenner Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) i signed by the a Id be detached fo 1 ☐ Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 this certificate has 1 Yes To the Hospitel or Attending Physician: ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 Certification: To 2 EP/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Manner of De th 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation I Director: / 2 Accident 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a

To the Funerel C

completely filled i 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059423 26 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltmore POB #303 For 5601 Loch Raven BIVD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 282006

32. Registrar's Signature

06-04394 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Robert Proescher 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 23, 2006 Proescher 0621 hrs Robert Wayne Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Baltimore Johns Hopkins Bayview Medical Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Country) 219-60-3427 Months Hours Director 09/24/1952 MD 53 1 X M Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b County 1 X Yes 2 No s 23a or 28a-f show e notified at once. Baltimore Maryland N/Apermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21206 U.S.A. 4717 Duncrest Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? Never Married 2 Yes 2 X No Specify: White Give Year 1 Yes 2 X No specify. Widowed 4 X Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Transport Truck Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Schloer Proescher, Sr. Be John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (brother) 12003 Codar Jano, Kingsville, MD Bruce Praeschen

Physician	I
/Medical	İ
Examiner	ı

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

	Examiner
100	Physician/Medical
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Medical Certification

State

Registrar

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day 2

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20a. Method of Disposition			Disposition (Name y or other place)	e of cemetery,	Da	ate 2	20c Location - City or	Town, State		
1 Burial 2 X Cremation 3 4 Donation 5 Other Speci			w Cremat				Baltimore,	_		
21. Signature of Funeral Service Lice	ensee						uneral Hom e, MD 2123			
23a. Part I. Enter the disease, or cor failure. List only one cause on Immediate Cause (Final disease	nplications that caused the each line. a. Head and Neck In		enter the mode of	dying, such as o	cardiac or re	spiratory arrest	, shock, or heart	Approximate Interva Between Onset and Death		
or condition resulting in death) Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequence Due to (or as a consequence)			-23-						
	X AMENDED 5 pe	r fh g	357 7−7 −	06 vt						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of the limit of the lim	2	Fetal death Other (Speci		ic pregnancy		23d. Date of delivery Month D	Day Year		
Part II. Other significant condition	s contributing to death be	ut not resulting	in the underlying	cause given in P	art I.		acco use contribute to 2 No 3 Prob	the cause of death? pably 4 Unknown		
						24a. Was an autopsy perform	prior to c	topsy findings availab completion of cause of s 2 No		
25. Was case referred to medical			2	6 Place of Death	(Check only	/ one)				
examiner? 1 ✓ Yes 2 No	Hospital: 1 / Inpatient			OA Other	Nursing H		esidence 6 Other	· · · · · · · · · · · · · · · · · · ·		
27. Manner of Death 1 Natural 5 Pending 2 Accident Investig				8c. Injury at Worl 1 Yes 2 ✓	_	d. Describe ho ibject assau	w injury occurred ulted			
3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of Injur		m, street, factory,	office building, e		or Town, Sta	eet and Number or Ru te) ood Avenue, Whi			
	ician: To the best of my k ner:On the basis of examir and manner stated					e time, date ar	nd place, and due to th	e cause(s)		
29h Signature and title of certifier	1		29c	License number	ſ		29d. Date signed (Mo.	nth, Dav, Year)		

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

June 24, 2006

Registrar's Signature

Assistant Medical Examiner

°8° 2006

			For Stata Registrar	,	epartment of Health and N Dertificate of Death	Mental Hygier Reg. t	7000 70010						
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death						
	Physicia		100 P	irson 5		June 19							
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	4	4c. County of Death						
		ш	Laurel Wood	Nursing Home			Cecil						
	Funeral		5. Social Security Number 6. Sex	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)						
	Director		23146.2013	73 Y	S.	May 311	933						
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits						
	daryl f sho	ō	MD Ceci	1 -	-141-10		1 PYes 2 □ No						
	the 1	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?						
	3a or	۵	367 Elatolaria	and Ad and IIA	21921		USIA						
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,						
ထ	or ite	Fur	1 Never Married 2 ☐ Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	o Hican, etc.)	Black, White, etc.						
ğ	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	To res 22 No Specily.		Specify: White						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. the than "natural; or items 23a or 28a-f show ant, the Medical Evantian Internation and	Completed	15. Decedent's Edu (Specify only highest grade	completed) (ecedent's Usual Occupation Give kind of work done during most of work	king 16b.	Kind of Business/Industry						
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Ċ T	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	en Sumame)						
Maryland	12 should be f n and Mental I is markad of reumetic ava	э Ве	Did Wine	lower	Ross	Dest	ONC						
<u></u>	mark mark	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print 19b. I	Mailing Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)						
Z S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumetic avant, the Medical Examinating the radiiled at ange.		Brounds Alourel	1 2.	3 chestnut Dr. 1	Elkaton	MD 2921						
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State						
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Baltimore,	permit. Departm Importa any inju		21. Signature of uneral Service Licens	se /	22. Name and Address of Facility	.1 -	- 11/8434						
ä	Ped Pin B		1 fent	I harch	ILAM 1232 MOVE	My Dr.	Jessy, PH						
	×		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do no	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between						
5	Phy sicia n		Immediate Cause (Final disease or condition	Premona.			Onset and Death						
	/Medical		resulting in death)	Due to (or as a consequence of):									
	Examiner	,	Sequentially list conditions,	6. Carinona faynx									
_	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of									
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Box (death certific e attending p ed for use as	ZM.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	205		23d. Date of delivery						
	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year						
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown									
	law requires that the as been signed by th 2 should be detache	by Physician/Me	Part II. Other significant conditions con	ntributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the cause of death?						
ırd	w require been sign	ed				1 Tes	2 No 3 Probably 4 Unknown						
ecc	ne law re has be ge 2 sho	pie				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Œ	The ate har page	Completed				performed? 1 ☐ Yes 2 % 7							
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	La called		th (Check only one)							
	shysi this c	၉	1 195 2 780	lospital:		ome 5 Residence							
n c	ling F	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Tir (Month, Day Year) Inj	me of 28c. Injury at ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred						
isi	Attending r death. actor: After y the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farr		28f Location (Street	and Number or Rural Route Number,						
Division of	lor A after Dira	Certification:	4 Homicide determined	building, etc. (Specify)	, ottoot, tastory, ottoo	City or Town, Sta							
_	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page				death occurred at the time, date and place								
	e Ho	edical	(Check only 2 Medical Exemi	ner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occu	rred at the time, date a	ind place, and due to the cause(s)						
	To the li within 2. To the I	Ř	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)						
)			I mi cell p	La_ MD	Do 4823		0/20/06						
	3		30. Name and address of person who co		ype, Print)	4	ctor 1121921						
				HSU, UD 22	-3 West green	5, 2	Gon H = 2192/						
	Sta Regist		31. Date filed (Month, Day, Year)	d2, Registrar's Signature	naste								

Examiner The law requires that the death certificate be executed Box 68760 P.0. Division of Vital

the attending physicien and hed for use as the burial-transit been To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

Il Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic avent

Physician /Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

6 31. Date filed (Month, Day, Year) JUN 2 8 2006

d certifier

29a. Certifier

29b. Signature and the

32 Registrar's Signature

MO

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print)

Joseph

certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

5

7 6

29d. Date signed (Month, Day, Year)

	•	State of Maryland / Department of Health and Mental Hygiene 2006 2031
Physician /Medica	n ai	1. Decedent's Name (First, Middle, Last) Barbara Christine Poist 2. Date of Death Month Day Year June 24, 2006 12:55AM
Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4c. County of Death 4d. County of Death 4d. South of Death 4d. County of Death
Director	-	231-36-5770 1 M 2 F 73 Yrs. Months Days Hours Min. (Month, Day, Year) Country) Usual Residence of Decedent 10a. State 10b. Country 10c. City, Town or Location 10d. Inside City Limits
4-06 (1)4,53Am death with the Maryland ome 23e or 28e-1 ehow remust be notified at	ector	MD Harford Joppa 10f. Zip Code 10g. Citizen of What Country?
4-06 death with me 23a or must be	by Funeral Director	507 Cider Press Court Unit D 21085 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
- あ モヨ l :	d by Fur	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Specify: White
1215-003 within 72 hours lene. than "natural", the Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 2 Nurse 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Healthcare
Ityland 21: Iryland 21: should be filed wit ind Mental Hygiens marked other th mattic event, the	To Be C	17. Father's Name (First, Middle, Last) Robert Ward 18. Mother's Name (First, Middle, Maiden Sumame) Ann Davis
S, Ma and 2 s m 27 le		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kristina Anderson-Daughter 630 Cider Press Loop Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore permit. Pages 1 Department of Ht Important: If Iten any Injury or oth		Oak Lawn Cemetery June 27,2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dunda 7922 Wise Avenue Dundalk, Maryland 21222
76(ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
.O. Box 68 the death certificat y the attending phy tched for use as th	nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ords, P	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
al Reco	Complet	24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No
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Divisi tal or Atten tal or Atten s affer deal of Director.	Certifica	Suicide 3 Suicide 4 Homicide 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospii nin 24 hour the Funeri npletely fill	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To To Cor		
12 Stat	_	31. Date filed (Month, Day, Year) 32 Aegistrar's Signature
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical Certification: To Be Completed	23d. By sa, outcome of pregnancy in the past 12 morffls? Yes 2 No 9 Unknown 1

		•	For State	State of	Maryland / De	epartme Certifica				•		2016	20319
			Registrar 1. Decedent's Name (First, Middle	. Last)			10 01 1			2. Date of De	Reg. No.		3. Time of Death
	Physici									Month	Day		
	/Medic		Dorothy Virging 4a. Facility Name (If not institution)	give street and numb	er)	4b. Cii	y, Town, or	r Location of	of Death	June	24 4c.	County of De	
1	Examin	er	Carroll Luther		Carroll								
	Euperal		5. Social Security Number		irthplace (State or Foreign Country)								
	Funeral Director		215-07-1214	908 Mai	cyland								
			Usual Residence of Decedent		98 Yr					Jan. 3	-, -	20011101	yrand
	how how		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	a-fs	cto	MD Cari	coll	Westmi	nster							1 ☐ Yes 2 X No
	th th	by Funeral Director	10e. Street and Number			10f. 2	ip Code				10g. Citi	zen of What C	Country?
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9	or It	F	1 Never Married 2 Marri	ed 1 ⊟Yes 27 If Yes, Give	Q{v₀		2 ∑ No	Specify:		,		Specify: W	
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5	nati	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. D	ecedent's U: Give kind of t fe. DO NOT	vork done	ation during mos	st of worki	ing	16b. Ki	nd of Busines	s/Industry
12	withir ane. than	m d	Elementary/Secondary (0-12)	College (1-4	or 5+)	ctapho	_				Mon	taomers	/ Wards
d 21	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show thit, the Medicel Esani retrinist er cellised at		17. Father's Name (First, Middle, I	_ast)	DI	ctapric	ne op			(First, Middle			walds
an	d be) Be	Harry P. Failin							a Brow			
7	houle d Me mark matie	2	19a. Informant's Name/Relationsh		19b. N	Mailing Addre	ss (Street a			I Route Numb		r Town, State.	Zin Code)
Maryland	d 2 s th an 27 ls trau	:	Dorothy Kirk	Niece		25 Bra				odbine			
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no	ages ant of t: If It y or c		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Lorrai				June 2006	29,	1,700	dlawn,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparantent of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Estantiant must be retilised at once.		21 Signature of Funeral Service I			22. Name	and Addres	ss of Facili	tv	·			
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			3a. Part Enter the disease, or shook, or heart failure. List	complications that ear	sed the death. Do no	-1212 t enter the m	W. OI ode of dyin	d Lit	cardiac o	r Road or respiratory a	Win:	Field,	MD 21.784 Approximate Interval Between
	Di		shook, or heart failure. List	only one cause on ea	h line.					-			Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Duran (or	as a consequence of	an t	erry	4	erse				
	Examiner				1-1 a Ca	. 10.0							
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760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	cal		d									
68	certifica oding ph use as th	Jed	IE FERMIE.										
Вох	th cei	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy n 2 D Fetal death	3 DEctopic	pregnancy	,			2	3d. Date of de	
	death on attended for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No		it at time of death	5 Other						Month	Day Year
P.0	at the by the	Phy.	9 ☐ Unknown										CIA
	requires that the een signed by th hould be detache	b	Part II. Other significant condition	ns contributing to deal	th but not resulting in the	ne underlying	cause give	en in Part I					to the cause of death?
ord	equi	ted	MADOLE	mar ces		-				10	Yes 2]No 3∏F	robably 4 nknown
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æ	The law ate has page 2 s	Completed							/		ormed? 2 □ No	death? 1 ☐ Ye	
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	I to a six of					of Death	(Check only o	one)		
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Sic	Attending r death. ector: After by the fune	cat	2 Accident investig 3 Suicide 6 Could r	et be		M		Yes 2 🗌		Of Leasting /	Ctroot	d Marshau au F	Tural Route Number,
Division	or Al	ertif	4 Homicide determi	ned 289. Place of building	Injury - At home, farm , etc. (Specify)	i, street, ract	ory, onice		1	City or To	wn, State,)	tural Houle (Vurnber,
	pitat ours a eral filled	edical Certification:	29a, Certifier 167 Certifyin	g Physician: To the b	act of my knowledge	death accurre	ed at the tim	ne date an	nd place	and due to the	221122(2)	204	o atatad
	24 ho Fun Fun	dica	(Check only one) Medical I	Examiner: On the basi and manner	is of examination and/	or investigati	on, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	3112 1110/110		/ 2	9c. License	e number			29d. Date	e signed (Mon	th, Day, Year)
	⊢≯⊢ŏ		1 /		1		DA	50	767	,	41:	2-6/1	
	\cap		30. Name and address of person	who completel cause	of death (Item 23) (T.	(De. Print)	7000)	183		1	1	
	4		686 C 100	(h) 1	Josh	fe 1	nd	2	105	7			
	Sta	ate	31. Date filed (Month, Day, Year)	32	istrar's Signature	- 4			y . 0				
	Regist		31. Date filed (Month, Day, Year)	2006	we It	boute	,						

DHMH 17 Rev 1/2001

06-04424 Helen Reeves

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State

e of Maryland / Department of Health and Mental Hygiene		2000	0000
Certificate of Death	D N-	2006	2036

	1- For State Registrar		Cen	tificate c	f Deat	h			F	Reg. No.	. 00	U 6.1	U J C
Physician/ ledical Examiner	Decedent's Name (First, Middle HELEN		Date of Dea Month June 24,	Day Ye 2006		3 Time of Dea 1119 hrs							
and the same of th	4a. Facility Name (if not institution Bon Secours Hospita	Death		4c. County	,								
Funeral	Social Security Number		Age (In yrs, Ia	st birthday)	Baltir If Und	er 1 Year	If Under	24Hrs.	8. Date of B	irth(MM/DD/YYY		hplace (State o	or To
Director	212-46-8852	1 M 2 🔏 F		61 Y	Month s.	ns Days	Hours	Min.	01/14	/1945	Foreign Cou	n _{Intr} MARYL.	AND
	Usual Residence of Decedent								01/11	7 1 3 1 3			
w any	10a. State 10b. County		10c. City,	Town or Loca	ation							10d. Inside Cit	
Aaryland 28a-f show 1 at once. ector	MARYLAND N/	A	1	BALT	IMORE					10- Citimon of M	lb et Cour	4.5	
ith the Maryland 23a or 28a-f sh notified at once	10e. Street and Number		10f. Zip	21216				10g. Citizen of What Country? U.S.A.					
vith the s 23a c		OOK AVENUE A	5 13. W				in? (Spec	cify Yes or N			can Indian, 8la	ck,	
death with r items 23 nust be no uneral	1 Never Married 2 N	Married Armed Force	s? 2XX No	If	Yes, speci	fy Cuban,	Mexican,	Puerto R	ican, etc.)	Whi	te, etc.		
ral", or	3 Widowed 4 XDi	vorced If Yes, Give Year or Dates:		1		X No				Specify:			
72 hours n "natur al Exam	15. Decedent's Education (Spi Elementary/Secondary (0-12			16a. Decede during	ent's Usual most of wo					16b. Kind of B	usiness/Ir	ndustry	
O036 within 72 giene her than ' Medical	10th grade) College (1-4 c	51 51)	SEA	MSTRI	755				N/A	Δ		
5-00 ed wit tygien other	17. Father's Name (First, Middle	e, Last)		DIF	1101111		8.Mother's	s Name (F	irst, Middle,	Maiden Surnam			
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica fo Be Comple				- Francis					E WILS				
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relation Nellie Dorsey									mber, City or Too , Baltin			21216
e, MD and 2 sho feath and item 27 is traumati	20a. Method of Disposition			lace of Dispo	sition (Na	me of cem			Date	20c. Location			2121
nore ages l art of F other	1 XXBurial 2 Crematic	Comment	State	rematory or o			v	06-	30-06	BALTI	MORE.	, MARYL	AND
Baltimore, MD 21215-C pernit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the I	4 Donation 5 Dther S 21 Signature of Fahera Service		01	22.	Name and	Address	of Facility			FUNERAL			
	(1)7	Puller		12	06 W	NORT	H AV	ENUE					1-41
Physician /Medical	23a. Part inter the disease, of failure. List only one caus	e on each line.								rest, snock, or ne	ert	Approximate Between On Deat	nset and
xaminer	Immediate Cause (Final diseas or condition resulting in death)				OTIC C	ardiov	ascula	ar dr	sease			Dean	''
	Sequentially list conditions,	b											
	if any, leading to immediate cause. Enter Underlying Cause		nsequence of	·):									
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last	D	nsequence of	·):									
		damended it	-em#23a 1	PTT 27 1	erMF.	857 7	16/06	717					
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical Ex	IF FEMALE:	23c. If yes, out			, ,	5007,7	70,00			23d Date of	f delivery		
∞	23b Was decedent pregnant in past 12 months?	the 1 Live birth		2 🔲 F	etal death	3	Ectopic	pregnand	су	Month			'ear
Box (e death ce the attenced for use	1 Yes 2 No 9 U	nknown 9 Unknown	: at time of dea	ath 5 [] [ther (Spe	ecify)							
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Division of Vital Records, tat or attending Physician: The law requir is after death. al Director: After this certificate has been s led in by the funeral director, page 2 should it briftication: To Be Completes.		11				26.Place	of Death (
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ion of tending Pt cath. total After the funeral cath.	1 Natural 5 Pe	28a. Date of (Month, Da	ay,Year)	200. 1	,,			No					
r Atter reader r	2 Accident Inv	vestigation 28e. Place o	f Injury - At ho	ome, farm, sti	eet, factor	y, office bu	uilding, etc	c. 2		(Street and Num	ber or Ru	ral Route Numb	ber, City
Division o Bospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral Contrification:	Suicide 6 Co	termined (Specify)							or Town,	State)			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendicompletely filled in by the funeral director, page 2 should be detached for use Completely filled in by the funeral director. To Re Completed by Physicial	29a Certifier	Physician: To the best o caminer: Dn the basis of e and manner state	examination a										
T S S	29b. Signature and title of certi		1/	/	29	c. License	number			29d. Date sig	ned (Mor	nth, Day, Year)	
	(IM.				O.C.N	Л.E.			June 25, 2	2006		
	30. Name and address of person	on who completed cause of			enn Stre	et Ralti	imore M	MD 212	01			-	
			strar's Signatu		JIII OUE	et, Dalti	in HOIE, I	VID 2 12	.01				
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Amend item#1,4b,pen*10,6857,77706 TT

Amend item#10b-c,10e-f,17, periot,6857,7713/06 TT For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** /Medical 4c. County of Death City, Town, or Location of Deatl 4a. Facility Name (If not institution, give street and number) Examiner Mitchelly Tie collinciton 6 Chesapeake Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) f Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months **55**□ M 060-09-04 2-8-1911 Director Texas Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or fleme 23a or 28a-f show any injury or other traumatic event, If a Wedical Example from the notified at once. MDAnnapoli: Anne Arunde 1 Yes 2 No Directo Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Road 10f. Zip Code 20721-2743 2 Kimber Ridge Ct. 21403 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. white 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife At Home 17. Father's Name (First, Middle, Last)
Unknown Oberdorfer 18. Mother's Name (First, Middle, Maiden Sumame) Miriam Tisdale Oberdorfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Seeger/daughter 2 Kimber Ridge Ct. Annapolis, MD 21403 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Crematory 6-24-2006 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Silver Spring, MD 21. Signature of Funeral Service Licensee mo1358 Rapp Funeral & Cremation Svcs.933 GistAve. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Duride /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? fibrillation 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner Be 26. Place of Death (Check only one) Othe Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2€ No P 1 Tyes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Medical Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 221 D47603 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 9169 Bouce, Wis 4000 Mutchellerle Dubaya, mp Will, An 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Greate) JUN 282006 Registrar

DHMH 17 Rev 1/2001

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	Examine	er	4e Fecility Neme (If			nber)			Catons	wn, or Locatio	on of Deeth	Balti	ty of Deeth				
			St. Josep 5. Sociel Security No.			7. Age (In yrs.	lest hirthday	If Under 1 Yea		24 Hrs. 8 F	Date of Birt	h		place (State	or Foreian		
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	186 T	5	10e. Street end Num	nber				10f. Zip Code				10g. Citizen o	log. Citizen of Whet Country?				
	3a or	<u></u>	1222 Tugw	ell Driv	e			21228				U.S.A.					
	deat	ner	11. Maritel Status		12. Was Dece Armed For	dent Ever in U	,S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori ben, Mexican	gin? (Specify 1, Puerto Rica	Yes or No-	- 14. R	ace - Ameri ack, White	can Indian, etc.			
21215-0036	within 72 hours efter death with the Maryland ena. than "natural", or items 23a or 28e-f show r.e. Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Marrid 3 ☐ Widowed		1 ☐ Yes If Yes, Giv Yeer or Da	2 <u>₹7</u> No e		1 ☐ Yes 2,☐,No			Specify.White						
5-0	72 hc 'natur	etec	(Speci	15. Decedent's E	ducation de completed)		16e. Dece (Give	edent's Usuel Occi e kind of work don DO NOT use retir	upetion e during mos	t of working		16b. Kind of	Business/Ir	ndu stry			
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lan	lantel ked o	To Be	Harry Alf	red Mach	rain-				Eliza	abeth F	Parrot	tt					
Maryland	nd 2 shoulth end M 27 is mer r traumat		19a. Informant's Na Susan Smi								Route Number, City or Town, State, Zip Code) 11icott City MD 21042						
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manylen Department of Health end Mantel Hygiena. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, tra Medical Examiner must be notified at once.			osition Cremation 3 [5 [Other (Special			emetery, cre	osition (Neme of emetory or other p Memoria]	ece) Park	1	ate 28-200		ion - City or Town, State kesville, MD		D		
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ital	ılclan: The cartificata rector, peg	Bec	25. Was case refer	red to medical					26. Place	e of Death (Cl	heck only o	one)			,		
5	<u>v</u> <u>v</u>	ဥ	examiner? 1 ☐ Yes 2 【	No	Hospital: 1 □ I	npatient 2	ER/Outpatie	ent 3LI DOA				dence 6 🗆 C		ity)			
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isio	Attending ir deeth. octor: Afta by the fune	ficat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be determined	e on Diese	of Injury - At h	ome, farm, s	treet, factory, offic		28f.	Location (S	Street end Nu	mber or Ru	ral Route Nu	ımber,		
Θį	after Direction	ert	4 🗌 Homicide	determined	buildi	ng, etc. <i>(Speci</i>	fy)				City or Tov	wn, State)					
	To the Hospital or Attent within 24 hours after deet! To the Funeral Director:	edical Certification:	29a. Certifier (Check only one)	1 ∄-Certifying Pi 2 ☐ Medical Exa	miner: On the ba	best of my kno asis of examina ner steted.	owtedge, dea ation end/or i	th occurred et the nvestigation, in my	time, date en opinion, dea	nd place, and ath occurred e	due to the	cause(s) and date and plac	manner es e, and due	stated. to the ceuse	o(s)		
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	1		30. Neme end eddr	ess of person who	completed caus	e of deeth (Ite	m 23e) (Type	02 (print)	le use	GATTE	we.	5300.	BADO	mope A	M Zrzy		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death June 24, **Physician** 2006 Richard Henry Shelley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 7, 1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Feb. 1₽M 2□F 218-32-2338 70 Vrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 23a or 28a-f ehov 7 is marked other than "natural", or itame 23a or 28a-f eho traumatic avent, the Mudical Experiment out the motified at Funeral Director Md. Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1115 Sturbridge Road 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1월 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Utilities Elementary/Secondary (0-12) 12 years College (1-4or 5+) (BGE) supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H is marked of John W. Shelley Dorothy A. Gerwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and important; if item 27 is m any injury or other traum once. Nora L. Shelley/wife 1115 Sturbridge Road, Fallston, Md. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 6/29/2006 Fallston, Md. Highview Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugleral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hnapla Stic /Medical Due to (or as a consequence of): Examiner one to a variable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the attershould be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 00 1 Yes 1 ☐ Yes 25

Day

Year

Year

0645

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 ☐ Yes 2 ☐ No

Maryland

white

26. Place of Death (Check only one Hospital: Opatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending

Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

luasailam M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D45530 602, SATWOOD, BELAIR 21016

State Registrar

Be

Certification: To

Medicai

25. Was case referred to medical

4 | Homicide

31. Date filed (Month, Day, Year, JUN 28

SUITE200) 32. Registrar's Signature

within 24 hours after To the Funerei Dire

06-04378 Demithrius Spears Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Mygiene

		For State			Certifi	icate of I	Death			Re	g. No.	100	p 2032
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gover.	4	a. Facility Name (if not institution	n, give stre	et and num	ber)	4b	City, Town,		of Death		4c. Coun	ity of Death	n
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	۵.	that t ed by detac	F.	Part II. Other significant con	ditions contributing to	o death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use coi	ntribute to th	ne cause of death?
	Division of Vital Records, P.O. Box 68	The law requires that the death certifica the has been signed by the attending pto age 2 should be detached for use as it					_			1 10	Yes 2□No	3 Prob	ably 4 Unknown
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		3		30. Name and address of per	son who completed c	ause of death (Item 2	3a) (Type,	Print)	(1	-10	115	M	1 122
		200	210	31. Date filed (Month, Day, Y	ear) 20	2. Registrar's Signatur	re ,		ans sy	cet Do	UT; MO	rellu	14 114 100
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America item 5 per fh 8857 7-6-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Otto B. Smith June 21 11:35 A M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 4458 8. Date of Birth (Month, Day, Year) July 18, 1929 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Florida 76 Yrs 266 42 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel; or iteme 23e or 28s-f show eny injury or other treumatic event, the Madical Examinar must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes X No Maryland Prince George's Fort Washington Be Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Kerby Hill Road 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXio Specify: Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Officer 0 U.S. Army (Ret Col) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ollie Brown Obie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 210 Kerby Hill Road, Fort Washington, MD 20744 Eva C. Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 9, Date 2006 20c. Location - City or Town, Stete Arlington, Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 6633 Old Aleandria Ferry Road

Lee FH Clinton, MD 2073 21. Signature of Funeral Service Licensee Clinton, MD 20735 1428681 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** he Koscleroti /Medical Due to (or as a consequence of): Examiner Sequentially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Mospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1245365 11701 livings for Rd Hlol, fort WARListon mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidanons, M.D 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State JUN 282006 Registrar

DHMH 17 Rev 1/2001

	,	ŀ	For State Registrar	State of M	1aryla:		artment of H		nd Mental Hy	giene 0	6 20328
A\$	Physicia		1. Decedent's Name (First, Middle		e W.	Schloss	snagle, S	r.	2. Date of De Month June		Year 3. Time of Death 4:30 P M
<u>}</u>	/Medic Examin	4	4a. Facility Name (If not institution	, give street and number	r)		4b. City, Town, or	Location of		4c. County of	
	- * E. \$		3411 Liberty F	arkway				Dunda			altimore
	Funeral		5. Social Security Number	6. Sex 7. A 1 ☑ M 2 ☐ F	ige (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
W.	Director		219-14-5278	I ZZI W Z L	81	Yrs.			July 22	2, 1924	Maryland
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	172 hours atter death with the Maryland "naturel", or Iteme 23a or 28e-f ehow idical Exercises must be notified at	Director		Baltimore				Du	ındalk		1 □ Yes 2403No
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W	,
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10	tter de r Item irer r	Funeral	11. Marital Status1 ☐ Never Married 2 ☑ Marrie	Armed Forces	5?				in? (Specify Yes or No Puerto Rican, etc.)	Black	c, White, etc.
21215-0036	el', o	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	· WW	II	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
2-0	72 ho	Completed	15. Decedent (Specify only highes	's Education it grade completed)		(Give	dent's Usual Occup	during most	of working	16b. Kind of Bus	siness/Industry
21	within ene. than "	jd L	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retired			Danido	ential Ins. Co.
	D 00 =		17. Father's Name (First, Middle,	1 Year		-	nsurance		's Name (First, Middle		
Maryland	ed la b	Be	John Tilden S		2			TO: MOUTO	Laura Gree		,
2	2 should be f and Mental b le marked of reumatic eve	2	19a. Informant's Name/Relationsl		ife	19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or Town, S	State, Zip Code)
Z	s 1 and 2 should f Health and Mer Item 27 le marke other treumatic		Mrs. Audrey I	. Schlossn	agle	3411	Liberty	Pkwy.	Dundalk,	Maryland	1 21222
ō,	s 1 and 3 f Health Item 27 other tr	1	20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	(6)	Date	20c. Location - 0	City or Town, State
E C	Page ent o nt: If ry or		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Оа	•	Cemetery	1	/24/2006	Baltimo	ore, Maryland
Baltimore,	permit. Pages 'Department of H Important: If Ite eny injury or of		21. Signature of Funeral Service	Licensee	,				al Home of		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the dea	ath. Do not en	er the mode of dying	ng, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	des direction	1110.	VT					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	as a conse	equence of):				·	
	Examiner		Sequentially list conditions	b. DYC	gre	50 Ve	A50	= ite	52		
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doe to (or a	s a conse	equence of):		Α	- G1		- /
	and -trans	Examin	that initiated events resulting in death) Last	c — Due to (o a	ne a conce	A	Poila	5 x <1	C=7/	3/70 W	- 19075
8760,	tate be executed obysicien and the burial-transit			540 10 (01)		14401100 01).	n				
687	icate phys s the	S S		d							
Box (leath certifica attending ph d for use as t	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-			23d. Date	e of delivery
	death e atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	at time of		∃Ectopic pregnancy ∃ Other (specify) _	/		Mon	nth Day Year
P.0	that the deed by the detached	hys	9 Unknown	9□ Unknown							
Vital Records, F	S C 6	þ	Part II. Other significant condition	ons contributing to death	but not re	esulting in the u	nderlying cause giv	en in Part I.		_	ibute to the cause of death? 3 Probably 4 Unknown
eco	e law requir has been si ge 2 should I	Completed				<u> </u>			24a. Was	osy pi	Vere autopsy findings available rior to completion of cause of
æ		S							perf		eath? □ Yes 2 No
/ita	ysician:] s certifical director, p	Be	25. Was case referred to medical examiner?				1 044		of Death (Check only	onel	
of	d S	은	1 ☐ Yes 2 No			☐ ER/Outpatie		4 1401		idence 6 Othe	
Ę.		on	27. Manner of Death 1 Natural 5 ☐ Pendin	ly .	Day Year)	28b. Time o Injury	Wor	yat rk? Yes 2 □ N		how injury occurre	JG .
isid	Attending r death ctor: After	icat	Accident investig	not be an Blace of	Injury - At	home farm st	reet, factory, office			Street and Number	er or Rural Route Number.
Division	5 4 5 6	Certification:	4 Homicide determ	building,	etc. (Spec	cify)	rest, factory, office			wn, State)	, , , , , , , , , , , , , , , , ,
	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in y the	edical C		ng Physician: To the be Examiner: On the basis and manner							
	To the To the To the Comple	Me	29b. Signature and title of certifie	r p 0	0	F 1 -	29c. Licens	se number		29d. Date signed	(Month, Day, Year)
)			3024			960	1.	-73	23		-16
jl	0+17		30. Name and address of person	who completed cause o	death (II	em 23a) (Type 76 M	erritt	Blut	L, Both	move,	Ind due to the cause(s) I (Month, Day, Year) Z/CE MD 21222
1	Sta Regist		31. Date filed (Month, Day, Year)	8 2006 32. Hegi	strar's Sig	nature A	perle				

		-	For State Registrar	State	of Maryland		artment of l tificate of		Mental Hyg	giene 1eg. No.	711116	20329
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	_	Eulalia Dora S	auble					June 24	٠,	2006	02:13 A M
	Examin		4a. Facility Name (If not institution	, give street and nu	imber)			or Location of De	ath		County of Death	
			Hidden Treasur		7 1 // //	- 4 6 546 /	Westmi If Under 1 Year		rs. 8. Date of Birtl		Carroll	Jaco (State or Foreign
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. la		Months Days			/ Year)	920 Mary	lace (State or Foreign htry) Land
	Director	-	218-07-3836 Usual Residence of Decedent		0.5	,			July 20	, -		
	yland yland		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mar e-fst	ctor	MD Carro	11	Mt.	Airy						1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number				10f. Zip Code			-	izen of What Cour	
	s 23a	rall	5350 Pommel Dr				21771	Nicolar Calaba			ed State	
	er de Items	Funeral	11. Marital Status 1 Never Married 2 Marr	Armed F		5. 13.	was Decedent of If Yes, specify Cul	pan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		Black, White,	
36	irs aft	by F	3 □ Widowed 4 □ Divorced	If Yes, G Year or	2 k No live ∆ Dates:		1□Yes 2∏ No	Specify:			Specify: Whit	ie .
ဗို	filed within 72 hours after deeth with the Maryland Hygiene. Ither than "natural", or Items 23a or 28e-f show ant, Ire Madical Examiner must be multified at	Completed by	15, Deceden	's Education	,	16a. Dece	dent's Usual Occu kind of work done	ipation	vorking	16b. Ki	ind of Business/In	
2	thin 7 e. an "n	ηpie	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retir	ed)	rorang			
7	ed wi	S		2		Seam	stress	10. Mathada A	lame (First, Middle,		wing Ind	ustry
nd	be fill stal H od oth	Be	17. Father's Name (First, Middle,	Last)					etta Linto		Surname)	
<u> </u>	12 should be filed within h and Mental Hygiene. 7 le marked other than "treumatic event, tre Max	10	Jessie Shipley 19a. Informant's Name/Relations	hin (Tyne Print)		19h Maili	ng Address (Stree		Rural Route Numbe		or Town. State. Zip	Code)
Maryland 21215-0036	id 2 s ith an 27 te i		Kim Novakowski		aughter		Pommel				21771	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If them 27 le marked other than "natural; or terms 23a or 28e-f show any injury or other treumatic event, if e Madical Exaculner mast be notified at once.		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name of matory or other pl	ace) T.	Date	20c. Lo	ocation - City or To	own, State
Baltimore,	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	-	n Mem. F		me 27, 2006	Fin	ksburg,	MD
äĦ	mit. I partm portel / inju		21. Signature of Funeral Service						neral Home			
m	permi Depa Impo any it		Jany B	Cauly		1	212 W. C	ld Liber	tv Road	Win	field, M	D 21784
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death each line.	n. Do not en	ter the mode of dy	ring, such as card	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician	10.5	Immediate Cause (Final disease or condition	_ a/ V	Necus	dust.	u Cu	lon e	-IA			Com
	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	uence of):						7
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consequ	uence of):						
	nsit	nine	Cause (Disease or injury	<								
	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to	o (or as a consequ	uence of):						
8760,	death certificate be executed e attending physicien and a for use as the burial-transit			d								
9	rtifica ng ph	Physician/Medical	IF FEMALE:					- 280				
Вох	eath certif attending for use a	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Petal	death 3	Ectopic pregnan	су		4	23d. Date of delive Month	ery Day Year
	the a	sic	1 ☐ Yes 2 █ No 9 ☐ Unknown	4∐Pre	gnant at time of de mown	eath 5L	Other (specify)					
P.0	requires that the di een signed by the hould be detached		Part II. Other significant conditi	ons contributing to	death but not resu	ulting in the u	inderlying cause g	oven in Part I.	23e. Did to	obacco u	use contribute to t	he cause of death?
ds,	uires than signed I	d by	Endreum	Punla	mson 1	2			101	/es 2)	No 3□ Prot	oably 4 □Unknown
Records,	> 40	ompieted	0		•				24a. Was		24b. Were auto	psy findings available
Be	9 - 9	omp							_ autop perfo 1 ☐ Yes	rmed? 2 No	death?	impletion of cause of
Vital	si cian: Th certificate rector, pag	BeC	25. Was case referred to medica	ı				26. Place of I	Death (Check only o	\rightarrow		-
of V	g 5 5	To E	examiner? 1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA		g Home 5 🗆 Resid			(y)
		on;	27. Manner of Death 1 Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time of Injury	W		28d. Describe I	now injur	ry occurred	
Sio	Attending r death. ector: After oy the fune	icati	2 Accident invest		ce of Injury - At ho	ome farm et		Yes 2 No	28f. Location (Street an	nd Number or Rura	al Route Number.
Division		ertification;	4 Homicide determ	nined 286. Fla	Iding, etc. (Specify	y) (121111, 30	7	5	City or Tox	vn, State	ə)	
	To the Hospitel or within 24 hours afte To the Funerel Dil completely filled in	O	29a. Certifier 1 Cartifyi	nysidan To	e st of my kny	ea	th occurred at the	time, date and pla	ace, and due to the	cause(s)) and manner as s	itated.
	e Ho 24 h e Fui	edicai	(Check only 2 Madical one)		asis of exa	n Ind/or ir	ivestigation, in my	opinion, death o	ccurred at the time,	date and	d place, and due to	o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title certific	er ///	MA			nse number			te signed (Month,	
				X	SSA	2.	177	5 Tale	۹ '	Ju	me 26	en zero 6
	0		30. Name and address of person	who completed ca	se of death (Item	23а) (Туре	Print)	A .	0 14	- 7	η	eh 2006
			31. Date filed (Month, Day, Year	Boxeles	egiştrar's Signa	AL SACH	from other	rether	تلنيلا بب	"Le	1 west	unter My
	St: Regist	ate rar	JUN 2		Boleva A	K A	and I					

pk perverneta

06-04190 Walter Smith

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			- For State	Certificate	of Death		g. No. 2000	2033
	Physicia	ın/	Decedent's Name (First, Middle,Last)			Date of Death Month	Day Year	3. Time of Death 0605 hrs
ledic	al Examii		WALTER SMITH 4a. Facility Name (if not institution, give street and	number)	4b. City, Town, or Location	June 17, 2	4c. County of Death	
			Harbor Hospital	number)	Baltimore	o, Death	N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Und	der 24Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Birth	place (State or
	Director		215-74-3708 1XM 2	49	Yrs. Months Days Hour	rs Min. 12–29	-1956 Foreign	ntry)MARYLAND
		E	Usual Residence of Decedent					
	w any	ı	10a, State 10b. County	10c. City, Town or Lo				0d. Inside City Limits 1 Yes 2 No
	Aaryland 28a-f show 1 at once.	ē	MD N/A	BALTIM	ORE 10f. Zip Code	110	og Citizen of What Countr	
	th the Maryland 23a or 28a-f sho notified at once	Director	2206 W. PATAPSCO AV	7	21230		USA	y:
	ith the 23a c				Was Decedent of Hispanic Or	rigin? (Specify Yes or No-		an Indian, Black,
	eath w	Funeral		Forces?	If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	
	after d	by F.	3 Widowed 4 Divorced If Yes, Give or Dates:	Year 1	Yes 2 X No specify	y:	Specify: BL	ACK
	natura Xami	eted b	15. Decedent's Education (Specify only highest of	durin	edent's Usual Occupation (Give ig most of working life DO NO		16b. Kind of Business/Ind	dustry
98	in 72 l	Bet		(1-4 or 5+)	LABORER		CONSTRUCT	TON
5-0036	led within 72 Hygiene other than the Medical	jdmo	17 Father's Name (First, Middle, Last)			er's Name (First, Middle, M	l	
215	e file ital Hy ked o	Be C	MILTON SMITH			ALICE STREAM		
21	P W W	P	19a. Informant's Name/Relationship (Type, Print)		of IV DAMARGE			
Q	• 5 5 E 6		UTISHA SMITH(WIFE) 20a. Method of Disposition		06 W. PATAPSCO	Date	20c Location - City or T	
Baltimore	es I and 2 of Health If item 2 ther traun		1 Burial 2 Cremation 3 Remova	I from State crematory of	or other place)		·	
im	Pagiment tant:	ļ	4 Donation 5 Other Specify:	METRO CR	EMATORY R Name and Address of Facil		BALTIMORE,	
Bai	permit. Page Department of Important: injury or oth		21. Si, etc. of Funeral Service Incensee JON	IB , HISK	1721-27 N. M			
Р	hysician	\dashv	23a Par I. Enter the disease, or complications the	at caused the death. Do not en				Approximate Interval
	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methad	one intoxication	and cocaine use		-	Between Onset and Death
	xaminer		minediate cade (i mai are are	as a consequence of):				
		ايا	Sequentially list conditions, if any, leading to immediate b. Due to (or a	s a consequence of):				
		Examiner	cause. Enter Underlying Gause (Disease or injury that initiated	as a consequence ory.				
	ad isit	Xar	events resulting in death) Last Due to (or a	as a consequence of):				
	ficate be executed g physician and the burial - transit		T UNPENDED AMENDE	n item#23a,27,28	Ba-f, perME, G857, 7/	6/06 TT		
760	te be e	Physician/Medical		es, outcome of pregnancy			23d Date of delivery	
3876	rtifica ling ph	au	23b. Was decedent pregnant in the	ve birth 2	Fetal death 3 Ector	pic pregnancy	Month Da	ay Year
B. V. G.	ath ce	sici	4 Pr	egnant at time of death 5	Other (Specify)		11.0	Ī
	w requires that the death certifications is been signed by the attending should be detached for use as	Ph	Part II. Other significant conditions contributing		the underlying cause given in I	Part I. 23e. Did to	bacco use contribute to the	ne cause of death?
٥	es that igned	ģ				1 Yes	2 No 3 Proba	ibly 4 🗸 Unknown
Ç	us, requir been s	Completed				24a. Was autop		opsy findings available mpletion of cause of
Ş	e law e has l ge 2 sh	립			-	perfor	med? death?	
à	ian: The certificate ector, page		25. Was case referred to medical		26.Place of Deat	th (Check only one)		2 [_] 110
<u> </u>	VILA hysicia this cer Il direct	o Be	examiner? 1 Ves 2 No	Inpatient 2 🗸 ER/Outpa	tient 3 DOA Other4	Nursing Home 5	Residence 6 Other:	
Ý	Attending Physician: The radeath. ector: After this certificate by the funeral director, page	<u> </u>	(N	onth, Day,Year)	e of Injury 28c. Injury at Wo		now injury occurred	
	ttendi death. ctor: y the f	atio	2 Accident Investigation	6/17/2006 FNd 5:				15
	INISION OF VICAL RECOLDS, F.O. Ital or Attending Physician: The law requires that the street ceath. The law rectors. After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	3 Suicide 6 X Could not be determined (Specific	Place of Injury - At home, farm, bify) Found at res		or Town, S Baltimore	Street and Number or Rura tate) 2206 W. Pat	apsco Ave.
	UNISION Hospital or Attend 24 hours after death Funeral Director:		4 Homicide	best of my knowledge, death				rd.
	UIVISION OF VICAL RECOURS, F.O. BOX 601 901. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the ba	sis of examination and/or inves	stigation, in my opinion, death	occurred at the time, date	and place, and due to the	cause(s)
	To sit	Mec	29b. Signature and title of certifier	er stated	29c. License numb	er	29d Date signed (Mont	h, Day, Year)
		1	6 6		O.C.M.E.		June 17, 2006	
	0		my no, mos					
	10		30. Name and address of person who completed					
	4	tate	30. Name and address of person who completed Ling Li, MD Assistant Medical E	xaminer 111 Penn S	Street, Baltimore, MD 2	1201		

SHELIA AND TURNER

06-03770 Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Date of Death 1 Decedent's Name (First, Middle Last) Physician/ Month 1401 hrs **Medical Examiner** June 2, 2006 SHEILA ANN TURNER 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death across from 601 Chelsea Road Aberdeen Harford 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number If Under 1 Year If Under 24Hrs 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign CountryMARYLAND Months Days Hours Director 08/27/1963 M 2 X F 42 219-86-4184 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location any Yes 2 X No 28a-f show is 23a or 28a-f sho e notified at once. ABERDEEN MARYLAND HARFORD CO death with the Maryland 10e Street and Number 10f. Zip Code 10g Citizen of What Country ā 649 HOLLY CIRCLE 21001 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14 Race - American Indian Black 11 Marital Status Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces? Yes 2 X No Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify Specify: BLACK or Dates:

15 Decedent's Education (Specify only highest grade completed) ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Ped during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical injury or other traumatic event, the Medical ē ltimore, MD 21215-0036 Compl GENERAL LABORER SELF 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETHEL MAE LEE CHARLES TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEL., 19802 Tyrone Lee/Brother 27th St., Wilmington, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State METRO CREMATORY 06-24-06 BALTIMORE, MARYLAND Donation 5 Other Spe 22 Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD,
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 21. Signat Rallin 23a. Patt / fixed the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical aNo identifiable anatomic or toxicologic cause of death Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED item#23a,27,28a-f,perME,g856,6/30/06 TT X UNPENDED requires that the death certificate be Division of Vital Records, P.O. Box 68760, attending physi for use as the bu IF FEMALE 23d Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should peen 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of has death? performed certificate Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene ٩ 1 V Yes No 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: Natural 1 Yes 2 No 5 Pending Fnd 6/2/2006 Fnd 1:51 pm unknown the Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number City Road Aberdeen, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide To the Hospital o within 24 hours af To the Funeral D (Specify) found in field 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal (Check only 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 3, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Day, Year State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

JUN 2

8 2006 06-04339 Robert Thompson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month June 20, 20	Day Year 006	3. Time of Death 1840 hrs
Annana de la companya		,	o. City, Town, or Location of Dea Takoma Park		4c County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Security Number 6. Sex 9. Security Number 6. Security Number 6. Security Number 6. Sex 9. Security Number 6. Secur	Months Days Hours M	_	Foreign	nplace (State or intrySC
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21215-0036 Uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	Be	L.D. Thompson		me (First, Middle, M	aiden Surname) ey	7 Onda)
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Te Hear		1 X Buria! 2 Cremation 3 Removal from State crematory or other	metery 6/	Date 28/2006	20c. Location - City or Suitland MI	
Baltimor permit. Pages Department of Important: If	- 1	21 Signature of Funeral Service Licensee 22. Na 261	me and Address of FacilityPo	Washingto	n DC 20020	
Physician /Medical Examiner	- 13	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/		al death 3 Ectopic preg er (Specify)	gnancy	Month D	ay Y ear
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Division of Vital Records, P.O. Box 68 ral or attending Physician: The law requires that the death certif its after death "al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Certification:	Natural 5 Pending Investigation 2 X Accident Suicide 6 Could not be determined 4 Homicide (Specify) Hospital	an	28f Location (S	eresis after fa treet and Number or Ru (ate) 3001 Hospit MD	ral Route Number City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	edical Ce		ed at the time, date and place, a	and due to the cause	e(s) and manner as start	ed.
5. ½ 5. 8.	Me	29b. Signature and title of certifier Aude Hallan	29c. License number O.C.M.E.		29d. Date signed (Mor June 22, 2006	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21	201		
S Regis	tate trar	e 31. Date filed (Month, Day, Year) JUN 2 8 2006	ade			
DHMH 17 Rev 1/2						_

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2006 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Bolton City to Kin By willes are Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security **Funeral** Hours 1 M 2 X Yrs. 92 May 29,1914 Maryland 215-03-4181 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f ehow 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Ext. cliner must be notified at 1 ☐ Yes 2√ No Nottingham Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21236 3726 East Joppa Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: Baltimore, Maryland 21215-0036 White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Assembler Manufacturing 8 Years permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: if Item 27 ie marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Forrest Louis F. McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21222 Baltimore, Maryland Mr. Neill W. Barber (Nephew) 3726 E. Joppa Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 6/29/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** demen Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ ₩o detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 JH To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ 28d. Describe how injury occurred Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 333/6 leted cause of death (Item 23a) (Type, Print) Kin Bayres Circle Baltimisa Mozier mo gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 26, 2006 June 12:33 AM Ada Taffetani /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Perry Hall Baltimore 9218 Sandra Park Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 02-23-1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 KK 88 Yrs. 217-38-7542 Italy Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Madical Exempter must be notified at Baltimore Perry Hall Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9218 Sandra Park Drive 21128 Italy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after if Heath and Mental Hyglene. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5th Cotlege (1-4or 5+) Clothing Tailor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Marie Fraticelli Giacomo Ciamberlini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louis Taffetani - Son 9218 Sandra Park Drive Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ite
eny Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fntombment Dulaney Valley Memorial 06 Signals I Dulaney Valley Memorial 06 Niner Jr. 22. Name and Address of Facility 06-28-2006 Timonium, Maryland 5305 Harford Road Part Leonard J. Ruck, Inc. Baltimore, Mark Shock or heart fair re. List only one cause on each line. Baltimore, Maryland 21214 Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) Cerebrova Pnysician 2 Mondh /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner the attending physicien and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated within 2 To the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 037612 6-26-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Tollgate Rd BelAIR MOZIOIS ALABRASH IMD 1601 MOHAMAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2006 Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar		artment of I			giene Reg. No.	006	20335
	Physicial		1. Decedent's Name (First, Middle, Last)			T. T.		2. Date of De	ath Day	Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of De	ath	4c. Co	ounty of Death	1
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	how	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
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	s 1 and 2 should I Health and Mer Item 27 le marke other traumatic		Donald Smith (Broth			01 Trappe		Apt. B I			· · · · · · · · · · · · · · · · · · ·
<u>6</u>	s 1 and 2 of Health Item 27		20a. Method of Disposition	20b.	Place of Dispo	esition (Name of matory or other pla	(ce)	Date	20c. Loca	tion - City or T	own, State
Ë	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		e Cemeter	1 1 .	/2006	Bal	timore	, Maryland
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	7 × 7	_) M	lh n	jh v	A .	01115	6	6/20	1/200	
-	7		30. Name address of person who co	peleted cause of death (Ite	m 23a) (Type,				2		
J			MELITO MIT	ornes, mo	441	S. EL	Lwood	AVE, 1	544	v. MI) 21224
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	hard!					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE **Physician** Oscar Melvin Whaley, Ir. 25, 12:50 PM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year - If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F 229-18-4960 93 Virginia 1912 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 4824 Brightleaf Court 21237 U.S.A. Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Rigger Bethlehem Steel permit. Pages 1 and 2 should be filled v Depertment of Health and Mental Hygiei Important: If Item 27 ie marked other It ery injury or other traumatic event, Ita once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Oscar Melvin Whaley, Sr. Washington Hanks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard P. Lioi, Sr. (son-in-law) 4824 Brightleaf Court, Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State Morriattico Bap. Ch.Cem.6/30/06 Kilmarnock, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month be detached for 4☐Pregnant at time ol death 5 Other (specify) o 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2□ No 1 Yes 1 Tyes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funerel Director: Alter thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification; 1 X Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 23 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 BOON POH LIM, M.D. 32. Registrar's Signature 31. Date liled (Month, Day, Year) State JUN 282006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / D	epartr <i>Certifi</i>	nent of H cate of L	ealth an Death	d Mental	Hygie Reg.	-	006	20	337
	Physici	36	1. Decedent's Name (First, Middle, Last)						2. Date of Month	1	Day	Year	3. Time o	f Death
	Physici /Medic			Gwend		Wade			6		18	2006	7:24	a ^M
	Examin	er	4a. Facility Name (If not institution, give st				City, Town, or	Location of D)eath		N/A	unty of Death		
- 0,	<u>, </u>		5715 Park Heights 5. Social Security Number 6. Sex		je (In yrs. last birt		alto Under 1 Year	If Under 24		of Birth			place (State	or Foreian
1	Funeral Director			M 20XF		Yrs. Mo	nths Days	Hours A	Vin. (Monti	h, Day, Ye 8- 1	954	Coui	ntry) Md	
			Usual Residence of Decedent											
	anylan ehow	_	10a. State 10b. County		10c. City, Town		n					1	10d. Inside C	ity Limits
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	ne 23	Funeral		2. Was Decedent		13. Was	Decedent of Hi	spanic Origin	? (Specify Yes	or No-	14.	Race - Americ		
'n	r Iten	필	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉)	If Yes	s, specify Cuba	n, Mexican, P	uerto Rican, etc	:.)		Black, White,		
ဗ္ဗ	ral', o	[호	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates:		101	∕es 2X No	Specify:			Spi	ecify: E	lack	
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a.	(Give kind	of work done	during most of	working	16t		of Business/In	,	
12	within one the n	d L	Elementary/Secondary (0-12) 10th grade	College (1-4or	5+) N/A		iOT use retired, Nurse)			нс	spital	-	
g 7	Hygie ther ont, it	ပိ	17. Father's Name (First, Middle, Last)		и/д		Nulse	18. Mother's	Name (First, M	iddle, Mai	den Sur	name)		
a	ld be ental ked o	To Be	James Rucker, Jr					Virgin	nia Greg	gory				
Maryland 21215-0036	shou and M s mar umat	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b.	. Mailing Ac	idress (Street a	and Number o	or Rural Route N	lumber, C	ity or To	wn, State, Zip	Code)	
Ž	elth a		Donnetta Wade - Da	aughter				Tuck W	lay Pik	4/4				
ore	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	20b. Place of cemeter	Disposition y, cremator	n (Name of ry or other place	a)	Date			on - City or To		
Ĕ	Pag ment lant:		4 □ Donation 5 □ Other (Specify)	1	Metro				23-2006	1.1		sville	, Md	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23 or 28a-1 ehow eny injury or other traumatic event, Ita Madical Examinar must be notified at once.		21. Signature of Funeral Service License	Irm	DAM	22. Na		-	March ash Aver		Wes Balt		21215	J
			23a. Part Enter the disease, or complice shock or heart failure. List only on	ations that cause e cause on each l	the death. Do r	not enter th	e mode of dying	g, such as car	rdiac or respirat	ory arrest,			Approxima Interval Be Onset and	tween
- 55	Physician		Immediate Cause (Final disease or condition		RESP	RAT	URY	for	LURC	-			Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):		. ()		_			
	4 /	<u>ا</u>	Sequentially list conditions, if any, leading to immediate	CIT/Co	a consequence	<u> 2 らら</u>	TRUCTO	JE 1	MYMON	PARCY	- (2	SSCA!	30.	
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9	ng ph	Physician/Medical	IF FEMALE:								Į.			
Вох	that the death certific ed by the attending p detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		opic pregnancy				23d.	Date of delive Month		Year
0	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	t time of death	5 Li Oth	er (specify)				ŀ			
Δ.	The law requires that the tte has been signed by th bage 2 should be detache		Part II. Other significant conditions con	tributing to death !	out not resulting in	n the under	lying cause give	en in Part I.	23e.	Did tobac	co use	contribute to t	he cause of	death?
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Ö	w require s been si should I	iete								Was an	2	4b. Were auto	psy findings	available
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ital		BeC	25. Was case referred to medical					26. Place of	Death Check		110			
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ت 0	Ing P		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. 1	Time of njury	28c. Injury Work		28d. Desc	cribe how	njury od	curred		
sio	Attending or death.	cati	2 Accident Investigation 3 Suicide 6 Could not be	00 - 51 (10	444 4-			Yes 2 No		ion /Ctros	t and M		10	
Division of Vital Records,	in Die	ertification:	4 Homicide	building, e	ijury - At home, fa tc. <i>(Specify)</i>	irm, street,	тастогу, оптсе			or Town, S		umber or Rura	ai Houte Nui	noer,
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exeminate		of examination an									s)
	o the o the omple	Mec	29b. Signature and title of certifier	and mainer's			29c. License	e number		29d.	Date si	gned (Month,	Day, Year)	
)	-> - 0		100000	~2.	m.0		Ba	89	(66031	0 (O (2	121	(0)	
•	1		30. Name and address of person who co	mpleted cause of	death (Item 23a)	(Type, Prin	1)	- 0 1	G0-0			1-11	21	211
1	4	ate	SOS MUT		rar's Signarite	Cons	2,600	Liber	66031 ty Hei	ins	Ane	Balti	nel	
	Regist		31. Date filed (Month Hay, 12 and 200	No parties	150 70	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year HILDA WHSHINGTON JUNE 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMONE RANDALISTOWN CENTER HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7-6) Nontetwest 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) Country 219-38-137 1 ☐ M 2 💢 F 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X es 2 No MI Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21207 Minna 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4yrs eacher Baltimore City Public 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Griffin George Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's ame/Relationship (Type, Print) Onzo Washington husband 7117 minna Rd Baltimore mo 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) roodlawn Vaughten France Baltimore, MD July 3,2006 21. Signal re of Fun ra Service Licensee uneral Services ene t Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or man failure. List only one cause on each line. Approximate Interval Between Onset and Death OF THE LUNG Immediate Cause (Final disease or condition resulting in death) SMALL CEIL NON Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 NO 1 Yes 2 No 25. Was case referred to polical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) 200 1 Depatient 2 ER/Outpatient 3 DOA 1 Tes 28a. Date of Injury (Month, Day 28c. Injury at Work?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28e-1 show

Items 23a

Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Item

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

2

treumatic event, the Medical Exerciner must be notified at

other

permit. Pages Department of Important: If It any injury or o

the Maryland

use as the burial-transit certificate the Hospitel or Attending Physicien: director, After death. Director:

The taw requires that the death certificate be executed

P.0.

Division of Vital Records,

Be Completed by Physician/Medical Examiner P Certification:

27. Mann of Death

1 Natural

2 Accident

3 T Suicide

29a Certifier

4 T Homicide

31. Date filed (Month, Day, Year)

JUN 2 8 2006

within 24 hours a To the Funerel I ical

State Registrar

29b. Signature and title of certifie

5 Pending

investigation

determined

6 Could not be

29c. License number

1 (Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

HESPITAL

MAnylow

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

119502

RANDAILS CON

2 🗌 No

1 🗌 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. CONANTO ONLANDO

2. Registrar's Signature

boarde

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

ORIGINAL

10:05

2006

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June 20 **Physician** 2006 8:00 РМ Mary Elizabeth Ware /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Comm. Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 € F July 25,1943 Maryland 369-44-6981 62 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or itema 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Capitol Heights **Funeral Director** Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 IISA 1004 Nova Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Yes. Give ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: natural Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 is marked other t jury or other treumatic event, in other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian E. Allen John Edward Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6506 W. Forest Road, Landover, MD 20785 Maria Ware-Thompson - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if iter
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 26,2006 Washington, D.C. Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Bolden Funeral Service 2504 28th St., NE, Washington, DC 20018 2a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of): **Examiner** Severe Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Severe Coronary Artery Desease Due to (or as a consequence of): P.O. Box 68760, Longstanding Diabetes Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown ted Severe Peripheral Vascular Desease 24b. Were autopsy findings available prior to completion of cause of death? Complet 24a. Was an autopsy performed? Gangrene Right Great Toe 1 ☐ Yes 1 ☐ Yes 2 No 25 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 158. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D21883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 ANNA POLIS, Rd. Suite # 315, LAXIHAM, M.D. 20706 HEMA PYADLA M.D 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 282006 Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2:15PM JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 9. Birthplace (State or Foreign Country) **Examiner** BAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 12) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1EM 20F 210-20-0132 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Specify ρ 3 ☐ Widowed 4 ☑ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if item 27 is marked other then "na eny injury or other traumatic event, Ita Meuling once. Elementary/Secondary, (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 19a. Inf -mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Demation 3 Removal from State 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Funeral Seprice tilcense 23a. Part 1 5 fter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) rung **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit the attending physicien and Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Kension 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

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State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 21, 2006 Fee Lan Wong 8:10 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia 5493 Greathead Court Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Dec 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 926 Toisan, China **Funeral** 1□M 3√7F Yrs. 227 94 5712 80 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. other than "natural", or flems 23s or 28s-1 show ant, the Medical Example or must be multified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Haymarket Virginia Prince William Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20169 13701 Piedmont Vista Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify:Chinese Specify. φ ¾\\\ Widowed 4 _Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is markad othn any lighty or other treumatic event, 9008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eng Shu Yee York Hong Yee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13701 Piedmont Vista Drive, Haymarket, Va 20169 19a. Informant's Name/Relationship (Type, Print) 13701 Piedmont Vista Drive, Haymarket, Michael J. Wong (son) 20b. Place of Disposition (Name of June 24, 2006 cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Surial 2 Cremation 3 Removal from State Suitland, Maryland Washington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service/Licensee 20735 D. Whont mo0257 Alexandria Ferry Road, Clinton, MD ronus Ant). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic CAVCINOMA Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probabty 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 21 No 2 No 1 Yes 1 TYes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) day hteris (for 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tune 21, 2006 mo 30. Name and address of person who completed cause of seath (ttem 23a) (Type, Print) les St. Balts. md 21204 Bmc 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2. 8 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend, item 14 per fh 8856 6-28-06 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 20363 For Stata Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:10 A M Dohaib Zulfigar June 20 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ne Hopkins HO altimore Johns Spita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 02 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**) M 2□ F 6 Yrs 99 NJ Director 152-06-7949 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes No Director White Marsh MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 U.S.A. 11501 Asbury Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after Nover Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ≥ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if Item 27 ie marked other than "eny injury or other traumatic event, If a Magagaga. College (1-4or 5+) Elementary/Secondary (0-12) na na nă na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tehmina Zulfigar 2 Zulifgar Cheema 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11501 Ashbury Ct, White Marsh, Md 21162 Ahmad Chattha-Uncle Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 6/21/06 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Massh F/H West
4358 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 N 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Adult doubt respiratory
Due to (or as a consequence of): distress 29 day Syndrome /Medical Examiner Se P515 dequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of) Examine signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Pneumonia Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hemopericardium 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Henothorax 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t director, paga 2 s autopsy performed? His bry of con
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2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

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32.

agistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

-baltimore

June 20, 2006

Please Type or Print in Black Indelible Ink 06-04472 State of Maryland / Department of Health and Mental Hygiene Emma Anderson 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1340 hrs June 26, 2006 **Medical Examiner** Emma Anderson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NI 1700 North Gay Street Apartment 213 **Baltimore City** 8. Date of Birth (MM/DD/YYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral Foreign Country) Months Days Hours Director 218.44.9063 63 12.04.1942 1 M 2 X Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County au's 1 X Yes 2 No Baltimor 23a or 28a-f show notified at once. MD with the Maryland Funeral Director 10g. Citizen of What Country? 10e. Street and Number Street Apt. 1700 North Gai 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married hours after death Yes 131ack Specify: If Yes, Give Year 1 Yes 2 No specify: 3 Widowed Divorced permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other tranmatic event, the Medical Examines. 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 House Leeder 8th avade 17. Fathers Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Almeta Be Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Anaela Manaum Beaumont 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place 2 Cremation 3 Removal from State 1 X Burial King Momorial Other Specify Donation 5 Name and Address of Facility AUMAN C. Breene HOS York Road 21 Signature of Funeral Service Licenses Puneral > NID
Baltinore NID 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed pur sician/Medical item#23a,2/,perME,g85/,//15/06 TI physician a X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician: Be Other₄ Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 V Yes No Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: 24 hours after death.

Finneral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Che Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the ! and magner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title June 27, 2006 O.C.M.F. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 🖯 20345 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Telise Barra June 24 2006 9:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Nursing Center Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6/20/1956 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 2□F 216-72-5982 50 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts r then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ZYes 2 □ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7215 York Rd. 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked perniit. Pages 1 and 2 should be fili Department of Health end Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 90cti. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Telise Barra Jr. Yetta Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dele Sangodeyi Social Worker 7215 York Rd. Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Cem 6/30/2006 Owings Mills, MD 22. Name and Address of Facility Sterling-Ashton-Schwah-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature of Funeral Service License Ralmette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ALZHEIMER'S DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to mission to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Ho spital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ပ 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 0 29c. License number 6/26/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
JUN 2 9 2006 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20341 State of Maryland / Department of Health and Mental Hygiene U U to Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1929PM 06 2006 BALLARD-COOPER ALIACYNELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING

If Under 1 Year If Under 24 Hrs. | B. Date of Birth (Month, Day, Year)

Pawe Hours Min. (Month, Day, Year) CROSS HOSPITAL MONTGOMERY HOLY 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex **Funeral** 1□M 2**X**F 061 05/2006 MARYLAND Director none Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No ROCKVILI Funeral Director MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 2085 BRUENTHER AUE SiA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) none none none none permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event, 9DRB. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ERIZABETH DENET BALLARD T COOPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1500 FOREST GLEN RD SILVER SPRING MD 20910 HOLY CROSS HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) insstate 21. Sign tur Ron Td S. Wade, ²State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 want 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Pause (Final **Physician** a RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner KTREME PREMATUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and s the burial-transit BIRTH WEIGHT EXTREME LOW that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown BUINAFILLASTUS GROWTH RESTRICTION Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🕱 No 2 X No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 - ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

State Registrar

E MINO 31. Date filed (Month, Day, Year) JUN 2 9 2006

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (It.m 23a) (Type, Print) 32 Registrar's Signature 1200

FOR EST GLEN RD SILVER SPRING MD 20910 Coase

29d. Date signed (Month, Day, Year)

06/12

DHMH 17 Rev 1/2001

29c. License number

D53509

20340 State of Maryland / Department of Health and Mental Hygiene 🔀 🕕 🕕 🖯 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 9:10 PM **Physician** BOOKHULTZ oncetta 25 June 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year)
Sept. 25,1927 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 35xF Yrs. Sept. 78 217-24-2084 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a. State 1 ☐ Yes 2√√No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or adical Examiner must be: USA 1843 Sutton Avenue 21227 by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 1x Widowed 4 □ Divorced al Hygiene. d other than "natura event, the Madical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: It liem 27 is marked other any Injury or other traumer: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Liberto Concetta Lascola ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lawrence Bookhultz II - Son 1843 Sutton Avenue; Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 6-29-2006 Baltimore, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fundal Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unorthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a P.O. Box 68760, Physician/Medical IF FEMALE 980 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊠Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ₺ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Alnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending Injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063653 June 26, 2006 lan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MD 21044 5755 Cedar Lane Evans Shawn \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 13 13 15

	1	For State Registrar	State o	f Mary		artmen ertificat		ealth and N Death		Reg. No.'	106	20349
Physician	1	Decedent's Name (First, Middle LEON	e, Last)	E		BRA	AFMAI	V	JUNE	26 ^{ay} 20	06 ^{ear}	3. Time of Death 11:55 P M
/Medical Examiner		4a. Facility Name (If not institutio HOSPICE OF BAL	TIMORE GIL	CHRIS				Location of Death				TIMORE
Funeral Director		5. Social Security Number 219-38-5107	6. Sex 1 M 2 □ F		o yrs. last birthday	Months		If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da 06/12/	1941	9. Birth	place (State or Foreign intry) MD
death with the Maryland me 23a or 28s-1 show tringed at the medial Director		Usual Residence of Decedent 10a. State 10b. County MD	N/A		c. City, Town or I							10d. Inside City Limits 1 X Yes 2 □ No
Je C//		10e. Street and Number 6406 CROSS CO	IINTDV RIVI	1		10f. Zip	Code 1215			10g. Citizen of		ntry? S.A.
036 urs after of, or the		11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Dec Armed For ried 1 Yes	edent Ever orces? 2 12 No	r in U.S. 13		dent of Hi city Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specii	ce - Ameri ck, White	can Indian,
Leon Cade led within 72 hours after tygiene. In the Medical Energian. Completed by Eur	onipiere	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College	1-4or 5+)	(Giv	edent's Usua e kind of wo DO NOT us F EMPI	rk done d se retired	during most of work)	king	16b. Kind of E		
Baltimore, Maryland 2121 permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if tiem 27 is marked other than any injury or other treumatic event, that sonce.	מ	17. Father's Name (First, Middle, SOLOMON				AFMAN		18. Mother's Nam SARAH			WI	EILLER
Mar Mar Ind 2 sh alth and 27 i e m	1	19a. Informant's Name/Relations MAXINE BRAFMA			1.	-		and Number or Rui DUNTRY BL		-		
Baltimore, Maryland Service, Maryland Service, Maryland Service Superiment of Health and Mentel Hymphorent: if tem 27 is marked oth my liquy or other treumatic event and services and the services of the ser		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (5	3 □Removal from	State	20b. Place of Disp cemetery, cri ALTIMORE	ematory`or o	ther plac		Date 28/2006	20c. Location REISTER	-	
Balti Permit. Departir importe eny inju		21. Signature of Funeral Service	Licensee	,					L LEVIN ROAD -			, INC. MD 21208
System of the burial-transit the	Jical Exa	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	for as a co	onsequence of):			g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
cords, P.O. Box 68 wrequires thet the death certification been signed by the attending planted by defected for use as is should be detached for use as intend by Physicilan/Med	yalcıdırıne	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 nant at time	Fetal death 3	□Ectopic pi □ Other (sp				1	ate of deliv	ery Day Year
ds, P. uires thet i		Part II. Other significant conditi	ons contributing to d	leath but no	ot resulting in the	underlying o	ause give	en in Part I.		bacco use con		he cause of death?
al Record The law requir cate has been s page 2 should									24a. Was autop perfo 1 □ Yes	rmed2	Were autoprior to codeath?	opsy findings available ompletion of cause of
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires thet the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Madical Certification: To Re Completed by Physician Madical Certification: To Re Completed by Physician Madical	2	3 ☐ Suicide 6 ☐ Could	Hospital: 1 28a. Date (Morigation not be 28a. Place)	Inpatient of Injury oth, Day Ye	2 ☐ ER/Outpation 28b. Time Injury At home, farm, s	of 2	28c. Injury Work 1 🔲 `	4 U Nursing Ho	ome 5 ☐ Resid 28d. Describe h	dence 6 Sott	rred	by Hospice
Div ospital or / hours after unerel Dire ly filled in b.		4 Homicide determined	ng Physician. To the Examiner: On the b	ing, etc. (S	Specify) ny knowlediga, dae	dh occurred	at tire tire	e, date and place,	City or Tox	m, State)	duudi da a	alalmi
To the Hospi within 24 hour To the Funer completely fill	Medi	29b. Signature and title of certific	and mar	ner stated		290	c. License	number		29d. Date signe	ed (Month,	Day, Year)
State Registral		30. Name and address of person 10 A Cile 31. Date filed (Month, Day, Yeal JUN 2 9		se death		p, Print)	arle	205t. 1	Balto.	Jone. Md	21,	50k 50k

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🚄 U 🖯 🖯 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** June 26, 2006 6:10 P^M Esther C. Clark /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year)
May 31, 19 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1□M 2∰F Hours 88 1918 197-09-4570 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County d 2 should be filed within 72 hours after death with the Marylan in and Mental Hygiene.
7 is marked other than "natural", or Items 23a or 28a-1 show traunatic event. The Medical Examinar must be notilited at 1 ☐ Yes 2 No Director Pylesville Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21132 USA 1707 Scott Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white white 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) os 1 and 2 should be fill of Health and Mental H Be Eltringham Esther B. Edwin K. Lessig Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1707 Scott Road Pylesville, MD 21132 Thomas Clark - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Metro Crematory June 28, 06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Pand. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Preumonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physicien Physician/Medical IF FEMALE: MA 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMBOLISM 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Philmanan 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Discose ANOUT 24a. Was an After this certificete has Diabers Mellitue 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death NA Injury 1 Mâtural 5 Pending 1 Yes 2 No after death. NA investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06.27.2006 D 0062704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kartis Pesai M.D. 500. Upderchesaperke Drive Drive Alt. M. MD Upperchesoperke

State Registrar

2. Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 2 9 2006 Raise

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\stackrel{<}{=} \stackrel{\bigcirc}{\cup} \stackrel{\bigcirc}{\cup}$ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 27 2006 10:10 A^M June Sedwick Carver Daniel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Crofton Convalescent & Rehab. Center 8. Date of Birth (Month, Day, Year) Nov. 19, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 XM 2 ☐ F Yrs Georgia 72 252-44-7250 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or itams 23a or 28a-f show the Medical Exercitive roughly at 1 ☐ Yes 2√☐ No Director Gambrills Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21054 United States 1024 Christmas Lane Completed by Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No 1955— If Yes, Give Year or Dates: 1957 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1957 white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sight Seeing Bus Bus Driver 11th Pages 1 and 2 should be filed nent of Health and Mental Hygin 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virdie Mills Nathan Carver ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Claudette E. Carver/wife 1024 Christmas Lane, Gambrills, MD 21054 27 20b. Place of Disposition (Name of cometey, crematory or other place)
West Arundel
Crematory 20c. Location - City or Town, State 20a, Method of Disposition ō <u>=</u> 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 6/28/2006 Odenton, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donaldson Funeral Home & Crematory, 1411 Annapolis Rd. Odenton, MD 21113 Thomas uanta R 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transil and Due to (or as a consequence of): attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at 1 be detached for ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tes 2 No 3 Probably 4 Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 Yes certificate 1 🔲 Yes director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 5 Pending Injury 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D40519 June 27, 2006

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

of Vital

Division

State Registrar Mirza Nusairee 1401 Madison Pa

31. Date filed (Month, Day, Year)
32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1401 Madison Park, Glen Burnie, MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	1	State Registrar 1. Decedent's Name	(First Middle 1 a	stl		Ce	rtificate of	Death	2. Date of Deat	eg. No.	3. Time of E	Death
sicia: ledica	n	i. Decedent's Name	s (First, Middle, La		allace	Cliftor	1		Month		0445	М
amine		la. Facility Name (/					4b. City, Town, o	or Location of Death Baltin		4c. County of E	N/A	
		5. Social Security N		CareCha		ge rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	9.	Birthplace (State or Country)	r Foreign
eral tor		245-18-8 Usual Residence of	803	M 2□F		Yrs.	Months Days	Hours Min.	(Month, Day,		No. Carolina	
		10a. State	10b. County	46	10c.	City, Town or Lo		altimore			10d. Inside City	
	Director	Maryland 10e. Street and Nur		/A		·····	10f. Zip Code		1	Og. Citizen of Wha		
-	ם ב	854 Bevans					10.12.6	21230		-	.S.A.	
	by Fur	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 X Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2¥∏No ve		Was Decedent of lif Yes, specify Cub	Hispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, N	American Indian, White, etc. Black	
	Completed	(Spec	15. Decedent's E cify only highest gr andary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.		pation during most of wor id) nt Seaman	king	16b. Kind of Busin	ess/Industry eants Assn.	
		12 17. Father's Name	(First, Middle, Las	1)			WIGICIA		ne (First, Middle,	Maiden Sumame)		
	To Be			Clifton					Gertr	ude Clifton		
		19a. Informant's N	ame/Relationship	(Type, Print)				t and Number or Ru reet Baltimore			ate, Zip Code)	
		20a. Method of Dis 1X Burial 2				cemetery, cre	osition (Name of matory or other pla stern Cemete	1	Date 07/06/06	20c. Location - Cit Baltin	y or Town, State	
DUCE		21. Signatur of Fu	aud	Y //. 7	3/1	70.	2. Name and Addr Estep B 1300 Eu	rothers Fune	ral Service, F	P. A. 21217		
		23a. Part1. Enter t shock, or hea	the disease, or con art failure. List only	plications that one cause on	caused the deach line.	eath. Do not en	ter the mode of dy	ing, such as cardiad	or respiratory arr	rest,	Approximate Interval Betw Onset and D	ween
		Immediate Cause disease or condition resulting in death)	on	a. Co		M400	PHTE				Unicrau	
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4	ner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease of that initiated event	onditions, nmediate	b. Due to		sequence of):	C) MCC	GC (
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	Completed by	ANE	niA						24a. Was a autop perfor	sy prio med? dea	re autopsy findings a or to completion of ca oth? Yes 2 \(\sum \) No	available ause of
	Be	25. Was case refe examiner?	rred to medical	Hespital			0	hor	ath (Check only or			
	lon; To	1 Yes 2 27. Manner of Dea	th 5 Pending	28a. Date (Mo.		2 ER/Outpatie 28b. Time Injury	of 28c. Inju	4 Vivursing F		ence 6 Other ((Specify)	
	Certification;	2 Accident 3 Suicide 4 Homicide	investigati 6 Could not determine	be 28e. Plac	e of Injury ding, etc. (Sp	At home, larm, s pecily)	treet, lactory, office		281. Location (S City or Ton		or Rural Route Numb	ber,
	edical C	29a. Certifier (Check only one)	1 Certifying F	aminer: On the	e best of my basis of exar	knowledge, dea mination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occi	e, and due to the durred at the time.	ause(s) and mann date and place, and	er as stated. d due to the cause(s)	:)
2	Me	29b. Signature an	d title of certifier				29c. Licer	ise number		29d. Date signed (/		
-		1		3	MD			207200	-	6/26/0		
		30. Name and add	iress of person wh		use of death		, Print)	Donel	ALO R	elt ha	21217	
		1/4/1/0	nth Day Year) UN 2 9 20	2 MO	16	\sim	11/2/	100 June		- 41		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Deneva 1:25 PM June 2006 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Balt, Mare 4c. County of Death UMM Sal If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F Months Days 215-40-6944 63 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 TYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Sterrett Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Home Health Aide 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Langston Logon Hattie Mae Deshields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Harvin Daughter 1234 West Lombard Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 06/30/06 Lansdowne, Maryland Mt. Zion Cemetery 4 □Donation 5 □ Other (Specify) 21. Signature Survice Ligensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the dista shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLONORA Due to (or as a consequence of): ens DOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) liabe' Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 1 Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Funeral

Director

or 28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interpretation 1 is marked other than "natural", or Items 23a or 28e-1 ehow any injury or other traumatic event, if a Madical Exprint activative notified at once.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Vital

Division of

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and I-transit The law requires that the death certificate be executed the attending physician this certificete

27. Manner of Death Certification

Medical

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IF FEMALE:

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

> State Registrar

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

1 Natural

2 Accident

3 🔲 Suicide

4 Homicide

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number

3 DOA

1 ☐ Yes 2 ☐ No

Other:

28c. Injury at Work?

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

212.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Right Eupric Mb IID S. Paca St. Euerle Snian 31. Date filed (Month, Day, Year) 32. Projetrar's Signature

2006

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b Time of

06-04338 Jooey H. Dorsey

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 20354

		1-For State Registrar	Ce	rtificate d	of Deat	th		R	Reg. No.	6. (10	0 2000
Physicia	n/	Decedent's Name (First, Middle,Last)		DODGEN				Date of Death Month Day Year			3. Time of Death	
Medical Examin		JOOEY	н.	DORSE				June 21, 2006				0858 hrs
		4a. Facility Name (if not institution, give: Prince George's Hospital Ce	4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's			's			
Funeral	4	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthdav)	<u> </u>		Under 24Hrs.	8. Date of Bi				hplace (State or
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deatl or ite	띪	1 Never Married 2 Married	1 Yes 2 X No		_			rticari, etc.		vviiite, t		A CIT
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Baltimore, permit Pages I an Department of Her Important: If ite injury or other it		21. Signature of Funeral Service License	e/. //					B. JENE				
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x 61	past 12 months?	ooth	2 Fetal death 3 Ectopic pregnancy th 5 Other (Specify)							,		
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Divis	Certification:	3 Suicide 6 Could not be determined	(Specify)					or Town, S				,
Hospi 24 hou Funer tely fil	_	29a Certifier	n: To the best of my knowled	dge, death occ	urred at the	e time, date ar	nd place, and	due to the caus	se(s) and	manner as	s starte	ed.
Divi	Medical	one) 2 Medical Examiner: 0	On the basis of examination and manner stated.									
F 3 F 5	ĕ∣	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mont							(Mont	th, Day, Year)		
June 22, 2								22, 200	6			
	İ	30. Name and address of person who co			0:	D "	ND 0	1004				•
		•	stant Medical Examin	er 111 P	enn Stre	et, Baltim	ore, MD 21	1207				
Sta Regist	ite	31. Date filed (Month, Day, Year) JUN 2 9 200	32. Fegistrar's Signat	K do	ale	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year S Druzik 247PM Stanley 14 2006 66 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Bayview Medical Center Johns Hopkins Baltimore Baltimore Birthplace (State or Foreign WV Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Months | Days | Hours | Min. | Months | Days | Months | Days | Months | Days | Months | Days | Months | Months | Days | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Mon 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 MM 2 □ F 233-42-3606 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State MD 1 Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 3019 Dundalk Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Deres 2 INO IPres, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Stee1 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph B. Druzik Wasilewski Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Greenridge Avenue White Plains, NY 10605 19a. Informant's Name/Relationship (Type, Print)
Rita Mathsen / niece 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory Inc. 2006 20a. Method of Disposition 20c. Location - City or Town, State Dian 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 26 Nemeral Office and Farthmeral Alternatives 19 8717 Green Pastures Drive Baltimore, Maryland 21286-Rita Mo1443 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Squamous Cell Carcinoma of Larynx 3 years Due to (or as a consequence of): Cardiac Systolic dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 157 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospitat: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Naturat 5 Pending t ☐ Yes 2 ☐ No investigation 2 Accident etermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit $\overrightarrow{+}$ $\overrightarrow{+}$ $\overrightarrow{+}$ Division of Vital Records, P.O. Box 68760, certificate has b irector, page 2 sl his After thi Director: within 24 hours efter d To the Funerei Direct completely filled in by t

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29a. Certifier

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29b. Signature and title of certifier

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permit. Page Department of Important: if any injury or once.

Physician

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Examiner

Maryland 21215-0036

Baltimore,

r than "naturel", or iteme 23a or 28a-1 ehov the Medical Examinar must be notified at

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) margate Ct, Pikesville, MD 21208 , 8834 Kevin Leahy

MD PhD

31. Date filed (Month, Day, Yar)
JUN 2 9 2005

32. Registrar's Signature 11461

1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

29d. Date signed (Month, Day, Year)

June, 14, 2006

Michael Otha Gilchrist

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	_	Under 1 Year lonths Days	If Under 24Hrs. Hours Min.	8. Date of Birt	I Fo	Birthplace reign	(State or
Director	ę	218-62-5551	1 M 2 F	54	Yrs.	24,5		06/18	11952	Country)	MD
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Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other traumatic event, the Marinjury or other traumatic event eve	Ī	1. Signature of Funer Sirvi	ceLiconsee		22 Name	and Address of	of Chicinics Co	ene 9	ineral	Ser.	1 ces
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Division of Vital Records, P.O. Box 68: To the Hospiral or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I	Medical Certification:	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer:On the basis	est of my knowledge, of examination and/o	death occurred a or investigation,	at the time, date in my opinion, e	e and place, and death occurred a	due to the cause t the time, date a	e(s) and manner as and place, and due t	started. o the cause	(s)
To COL	ğ	29b. Signature and title of cer	and manner	stated.		29c. License	number		29d. Date signed	Month, Day	(,Year)
		\	J. NVI.	16		O.C.M	1.E.		June 26, 2006	; 	
10		30. Name and address of pers Jack Titus MD. D	son/who completed ca eputy Chief Med			Street Baltin	more, MD 21	201			
Sta	ate		ar) 32.	Registrar's Signature	- ITT GIIII	A COL DAM				· · · · · ·	
Registi	rar	31. Date filed (Month, Pay Yea	9 2006	Begins &	Sports						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 [] [] Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Year **Physician** 23,2006 1049AM GOODWIN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY GOOD SAMARITAN B4LTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months Hours 1XM 2□ F MARYLAND 220-52-3997 56 Director 04/21/1950 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits iral', or iteme 23a or 28a-f ehov Examiner invel be cutilied at $A \setminus N$ XXYes 2 No MD BALTIMORE CITY Completed by Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6514 BROOK AVENUE 21206 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after nent of Heatilb and Mental Hygiene.
ent: if item 27 ie marked other than "natural; or ite
ury or other treumatic event, the Maulical Examinaury or other treumatic event, the Maulical Examinaury or other treumatic event, the Maulical Examina-1X Never Married 2 Married 1 ☐ Yes XX No Specify. BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) DISABLED DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN PRICE ROBERT GOODWIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Heath ar importent: if item 27 ie eny injury or other treu once. HELEN PRICE / MOTHER 6514 BROOK AVENUE, BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/27/06 METRO CREMATORY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature yneral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, her the lisease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest in head failure. List only one cause on each line Approximate Interval Between Onset and Death Immedial Cause (Final disease r condition ACUTE MYOCARDIAL Priysician diseas r condition resulting in death) /Medical ue to (or as a consequence of) Examiner CARDIOVASCULAR ATTAEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural
2 Accident 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funeret Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) JUN 2 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH

32 degistrar's Signature

PAVEN

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 06/26/2006 04:15 PM Gabryszeski /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/16/1923 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 212-20-2593 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 232 and any injury or other traumation. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Queen Annes Stevensville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 313 Bay City Road 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Dept. Supervisor Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Gabryszeski Josephine Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Water Fountain Way; Glen Burnie, MD 21060 Mr. Glenn Gabryszeski / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 06/30/2006 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Clen Burnie, MD 21061 anh MO1357 23a. Part 1. Et ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the fit failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician stage NOC. /Medical Examiner 5-quantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Exam Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant I ive birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 Tes 211No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one SSISTED Other: 4 Nursing Home 5 Residence 6 Dother (Specify) မ 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type, Name and address of person 86 (100 U

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

			1 - For Registrar	State of Ma	aryland / [Department of I Certificate of	Health and N <i>Death</i>		ene 2 () ()	6 20359	
			1. Decedent's Name (First, Middle, I	ast)				2. Date of Death		3. Time of Death	
	Physici /Medio		GEBRE		Month 6	Day 200	6 1657 M				
p.	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
	Funeral Director		HOLY CROSS HOSPITAL 5. Social Security Number 6. Sex 12M 2 F 7. Age (In yrs. last birthday) Yrs. SLUER SPRING Montro 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) Control (Month, Day, Year) Ob 06 2006 Me								
	pur .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location				10d. Inside City Limits	
	fanyli oho	ក	,	GOMERY	SILV		N.C.			1 XYes 2 □ No	
	28a-	Director	MD MONT	GUMERY	SILV	10f. Zip Code	76	10	g. Citizen of What (Country?	
	with ser	<u></u>		KLEAF DI	0 #132		106		USA		
	ms 2:	era	11. Marital Status	12. Was Decedent I		13. Was Decedent of I	10	ecify Yes or No-	14. Race - An	nerican Indian,	
5-0036	be filed within 72 hours efter deeth with the Maryland tal Hyglene. d other then "natural", or items 23a or 28a-1 ehow event, I'm Medical Examinar must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:	10	If Yes, specify Cub		Rican, etc.)	Specify: S	LACK	
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2121	within ene.	ng.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use retire	d)	9			
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<u>a</u>	2 sh and ie m		19a. Informant's Name/Relationship		1	. Mailing Address (Street			248 58		
altimore, I	Pages 1 and 2 should b nent of Health and Ments ant: if Item 27 ie marked ury or other traumatic e		HOLY CROSS 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 QOther (Spee	□Removal from State	20b. Place o cemete.	Disposition (Name of ry, crematory or other pla			Oc. Location - City of	RING NO 1096 or Town, State	
Balt	permit. Page Depertment of Important: if eny injury or spece.		21. Signature Euneral Service Lice	wade, Dir	ector	State Anat	ess of Facility Comy Board MD 2120	655 W.	Baltimore	Street	
			23a. Part1 Enter the disease, or co shock or heart failure. List on	mplications that caused	the death. Do	not enter the mode of dy	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
Physician /Medical			Immediate Cause (Final disease or condition resulting in death)	a Myoc	•	AL ISCH	EMIA			Onset and Death	
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P.O. Box	at the death certifi by the attending teched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	t 12 months? 4 Pregnant at time of death 5 Other (specify)						elivery Day Year	
	quires that n signed b uld be dete	b	Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.							to the cause of death? Probably 4 Unknown	
Division of Vital Records,	. The law requires that the sate has been signed by th page 2 should be deteche	Completed						24a. Was an autopsy perform	ed:? death?	autopsy findings available occupietion of cause of	
ita	sicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					h (Check only one			
<u></u>	Physic this ce al dire	은	1 ☐ Yes 2 No	Hospital: 1 Inpatie		itpatient 30 box		me 5 Resider	ce 6 □Other (Sp	ecify)	
sion o	Jing I		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	- 1	ry 28b. 1	Time of 28c. Injury Wo	ry at rk?] Yes 2 □ No	28d. Describe how	vinjury occurred		
DIX.	ital or Attencrs after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination an	e, death occurred at the ti d/or investigation, in my	me, date and place, opinion, death occur	and due to the cau	use(s) and manner a e and place, and du	as stated. ue to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)	
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1	MH.		30. Name and address of person wh	o completed cause of d					- March 1991		
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	Sta Registi		31. Date filed (Month, Day, Year)	2006 32 Registra	ar's Signature	Goods.					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene | | | | | For State Registra 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Florence Heinrich 4:52 AM Tune 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland medical center Baltmore, Maryland University If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 212-12-4772 Director New Jersey 84 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "naturel", or itema 23a or 28a-f ehov The Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Truck House Road 21146 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after I □ Yes 2 🕱 No f Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) g Homemaker Own Home of the and Mental Hygie 27 is marked other reference. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gerrit Jan Hockstra Marie Gertrude Allard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 is any injury or other trau 24129 Pecan Grove Lane; Gaithersburg, ND 20882
e of Disposition (Name of Date 20c. Location - City or Town, State George C. Heinrich Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 7/3/2006 Owings Mills, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Division of Vital Records, P. signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death / Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 No 1 Vinpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18550 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) achel Greene Barmer The 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** linton MACP Harylana 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Number **Funeral** Days 1 M 2□ F Hours Director none Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Forestville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20747 USA 3406 Little Hill Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٥ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black ۵ ear or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Erika Herbert Brian King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD 20735 Southern Md Hospital Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director un Baltimore, MD 21201 3a. Part1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner 9 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate has director, page 2 2 No 1 ☐ Yes 2 2 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this. funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SArratts 7503 Registrar's Signature 31. Date filed (Monta State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 620362

					(Certi	ficate of	Death		Reg. No.		6.000
	Dharaisi		1. Decedent's Name (First, Middle, La	st)			_		2. Date of		Year	3. Time of Death
	Physici /Medio		MILTON				HANTMA	٩N	JUN		OCL	1345
Vp.	≺ Examir		4a. Facility Name (If not institution, giv	e street and number)		NUI	->1:-U	and the same of th	n, or Location of D	eath 4c. Coun	ty of Death	
			BROOKE GROVE REI	HABILITATI	ICH AND	CE	NTER	SAND			JT 40	DMERY
Г	Funeral		Social Security Number 6. S		e (In yrs. last birth	1	If Under 1 Year Months Days		4 Hrs. 8. Date o	f Birth J. Day, Year) 0/1915	9. Birthp	place (State or Foreign
	Director			X M 2□ F	90 Y	rs.	,		09/06	71915		""/ PA
	D >		Usual Residence of Decedent 10a, State 10b, County		40 - Oit Tour		41					
	anyla eho det	<u>_</u>	MD MONTGON	#EDV	10c. City, Town		SPRING				'	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	5		ILKI	SILV	EK .						
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ıtry?
	ath w	Funeral	3114 GRACEFIELD F				20904				S.A.	
	tems	l e	11. Marital Status	12. Was Decedent I Armed Forces?		13. Wa If Y	s Decedent of F es, specify Cub	Hispanic Origir an, Mexican, I	n? (Specify Yes o Puerto Rican, etc.	r No- 14. Ra	ice - Americ ack, White,	
20	s afte	by F	1 ☐ Never Married 2 (五) Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give	10	10	Yes 2 No	Specify:		Speci	_{ity:} WH:	ITE
8	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-f ehow ant, the Medical Exantiner must be notified at	D D		Year or Dates:	10- 1) d	Wa Haval Oaar			405 165-4-41		
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0	filed Hygid ther	ပို	17. Father's Name (First, Middle, Last)	-	UWIN	L1X		18. Mother's	s Name (First, Mic	ddle, Maiden Suma		
an	d be antal	Be C	MORRIE			HAN	ΓMAN		LIE		,	MILLER
Maryland 21215-0020	should ind Men marke umatic	ို	19a. Informant's Name/Relationship	Type Print)						umber, City or Town	State Zin	
	C1 00 00 00		LINDA HANTMAN / E		105.	_				CKVILLE,		•
Baltimore,	1 and Health em 27 other tr	18	20a. Method of Disposition		20b. Place of I	Disposit	ion (Name of		Date	20c. Location		
<u></u>	Pages nent of I nt: If ite iry or o		1 N Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	MONTEFI		tory or other pla	ce)	1.20	PHILADE	-	
Ξ	it. Puritme		21. Signature of Funeral Service Licen		MONTELL	_	lame and Addre	ses of Eacility				
ga	permit. F Departmo Importar any injur		21. digital de of Furieral de vice Elder	300				_		INSON & B		
			nous /c	from						- PIKESVI	LLE,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lir	the death. Do no ie.	ot enter	the mode of dyir	ng, such as ca	ardiac or respirato	ry arrest,	i	Approximate Interval Between
	Physician		Increasion Course /Final)	Onset and Death
1/2	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a ASPIR	MOTA	P	NEU N	uani.	A			NEEKS
		7	,		Due to (or as a co		nce of):					
Г	ted nsit	듣	•	b. DYSP	HACTIA		,					MONTHS
	certificate be executed rding physician and use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a co						200	
9	siciar buri		Cause. Enter Underlying Cause (Disease or injury that initiated events	SENII				A			/	MONTHS
09/89	icate phys	edical	resulting in death) Last	l	Due to (or as a co	nseque	nce of):					
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ň	res that the death is signed by the attended by the attended for un	Physicla	Dort II. Other significant conditions of	and the standard by	st mat sacritina in s			en in Dani I	anh I	Did Anhanan		Alter annual of de-NLO
0	the c y the	hys	Part II. Other significant conditions of			_				A .		the cause of death?
.ر. ت	that ned b	by P	DIABETES	LELLIT	US; A	FTR	IALF	-IBRIL		I ☐ Yes 2 No	3 FIO	ADIY 4 □ UIIKIIOWII
Vital Records, P.O. B	To the Hospitel or Attending Physicien: The law requires that the death within 24 hours after death. To the Funerel Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2.	ğ D	. A = .						24a. V	Vas an autopsy	24b. We	ere autopsy findings
င္ပ	A red beel shot	Completed	LATION						p	erformed?	CO	ailable prior to mpletion of cause death?
2	ne lav s has ige 2	ᇤ								□Yes 2 No		
<u>a</u>	n: Th ficate or, pa		25. Was case referred to medical					00 8			1 L	Yes 2□No
5	sicie certi irecto	o Be	examiner?	Hospital:	nt 2□ ER/Outr	ntiont	a□ DO A Oth		f Death (Check or	<i>nly one)</i> Residence 6 ⊟Otl		.1
0	Phy r this aral d	<u>1</u>	27. Manner of Death	28a. Date of Injur	y 28b. Tir		3□ DOA 28c. Injur	y at		ibe how injury occu		<u>"</u>
Division of	ding th. Afte	ţ	1 Natural 5 ☐ Pending investigation	(Month, Day	Year) Inj	ury	Wor	nk? Yes 2∐No		, ,		
S	deal deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be		ıry - At home, farr	n, street	, factory, office		28f. Location	on (Street and Num	ber or Rura	l Route Number.
5	after Dire	Certification:	4 ☐ Homicide determined	building, efc	."(Specify)				City or	Town, State)		
	To the Hospitel or Attending Physicien: The law require within 24 hours after death. To the Furerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should	alC	29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge,	death or	ccurred at the tin	ne, date and p	place, and due to	the cause(s) and m	anner as st	ated.
	e Ho 124 h e Fui	edical	(Check only 2 Medical Exam	iner: On the basis of	examination and/	or inves	tigation, in my o	pinion, death	occurred at the tir	ne, date and place,	and due to	the cause(s)
	Vithir Co th	ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signe	ed (Month, i	Day, Year)
			homas	ATTENDIL	17 PHYSI	CIAN	D4	204	6	JUNE	27	2006
			30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Pri	nt)	- '	_			208/00
	15		GRACE BLOOKE ITV	FMAN L	LD. 1810	DSL	ADESC	TOOL !	ROAD SA	NDUSPE	N/2 1	LARY ALD
	Sta	te	31. Date filed (Month, Day, Year)	32. Regetra	r's Signature	_	1 . 11 .			7 5,7		110170
	Registr		29b. Signature and title of certifier 30. Name and address of person who compared to the service of the servic	2006 Hear	we S.	169						
_						_						

06-04457 Robert Lee King

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 20363 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Medical Examiner Robert 2317 hrs June 25, 2006 hing 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Balitimore 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Director Months Days Hours Min 216-02-7900 1 X M 2 1968 Country) MDUsual Residence of Deceden any 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. impR Director s 23a or 28a-f e notified at c 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 1 X Yes Widowed 4 X Divorced If Yes, Give Yea Yes 2 X No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " Baltimore, MD 21215-0036 NA Installer omcast able 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Robert Be is marked Jaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 injury or other trauma Hobert L unne Haven DR. Windspe 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation FOREST Donation 5 Other Specify Owings Hills 22. Name and Address of Facility Youghn C. Gleene 21. Signature of Funeral Service Licenses Funeral Natl Pike. Balto. Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical a. Gunshot wound of head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical UNPENDED AMENDED e attending physician for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? 2 Pregnant at time of Other (Specify) Yes 2 No 9 Unknown death Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? r this certificate h Yes 2 1 🗸 Yes 2 Nα Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ DOA ER/Outpatient 3 Nursing Home 5 Residence 6 7 1 ✓ Yes No After the 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred ion Subject shot Natural FOUND: within 24 hours after death. Pending Yes 2 V No To the Funeral Director: completely filled in by the Jun 24, 2006 Certificat 0515 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 600 Aisquith Street, Baltimore, MD 4 V Homicide determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. June 27, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Month, Day Year 31. Date filed (Month 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of rtificate or	Health and f Death	Mental Hy	/giene	20364
-2	Physici	an	Decedent's Name (First, Middle, Last IRENE KOH					2. Date of De	26,2006 Year	3. Time of Death
4/6	/Medio Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Dea	JUNE	4c. County of De	
7	Funeral Director		5. Social Security Number 213-34-7201 Usual Residence of Decedent	х Эм 2XЭF 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 Hr	8. Date of Bi (Month, Di MAR.	rth 9. B	rthplace (State or Foreign COUNTRY) CRAINE
, Maryland 21215-0036	iges 1 and 2 should be lited within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f ehow if it item 27 is marked other than "natural", or itema 25a or 28a-f ehow or other traumatic event, the Madical Examiner must be notified at	To Be Completed by Funeral Director	10a. State MD. BALTIM 10e. Street and Number 2505 MICHELS LA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) REV. BASIL SUSH 19a. Informant's Name/Relationship (T) ANNA KOHUT/ DAU	IORE 12. Was Decedent Ever in U. Armed Forces? 1	16a. Deced (Give life. HOUS	MORE 10f. Zip Code 21 Nas Decedent of the service of the servic	Hispanic Origin? (: ban, Mexican, Puel o Specify: upation e during most of worded) 18. Mother's Na MARIA	orking me (First, Middle A KULC ural Route Numb	Specify: Washines 16b. Kind of Busines DOMESTI D. Maiden Surname) ZYCKI Der, City or Town, State,	erican Indian, ite, etc. IHITE s/Industry C
Baltimore,	permit. Pages 1 a Department of He Important: if item any injury or oth once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State ST.	lace of Dispo emetery, cren MICH	sition (Name of natory or other pl AEL'S (. Name and Add ILLY & 901 EAS	JKRAINIA JKRAINIA JEILER ZEILER STERN AV	INC. F	20c. Location - City of ALTI UNERAL HOALTIMORE,	MORE, MD.
	Physician	dical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	PU 55 RS	SE/ WITH Plence of): P/EYU	ectric oraci	al Ars	hythm.	nrest, NG	Approximate Interval Between Onse and Death 34/M 440/S
.O. Box 6	that the death certificated by the attending portes as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 □ Yes 2 ■ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnant	су		23d. Date of de Month	livery Day Year
Records, P.	w requires s been sign should be	Completed by Ph	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the ur	nderlying cause g	iven in Part I.	1 🗆 24a. Was	an 24b. Were a prior to death?	or the cause of death? robably 4 Whitnown utopsy findings available completion of cause of
Division of Vital Records,	Physician: this certific al director,	Certification: To Be C	25. Was case referred to medical exampler? 1 by Yes 2 No F 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	P/Outpatien 28b. Time of Injury	28c. Inju	ther: 4 Nursing Hury at ork? Yes 2 No	ath (Check only of dome 5 Residence 128d. Describe	dence 6 Other (Spe	icity)
Div	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certif	4 Homicide determined 29a. Certifier 1 Certifying Physics	28e. Place of Injury - At hor building, etc. (Specify, sician: To the best of my knowner: On the basis of examination and manger stated.	vledge, death	occurred at the t	ime date and place	City or Tox	Cause(s) and manner a	estated
)	To the within ; To the comple	Mec	29b. Siggratu/Vahr hive of Certifier	and manyor stated. ML)	29c. Licen	se number		29d. Date signed (Moni	h, Day, Year)
	Sta Registr		30. Name and address of person who concern the second seco	mptoted cause of death (Item WHILL CS 32. Registrar's Signati	road a	Samar	itan 1	Kospita	JER	

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	ate of Maryland /	Depa <i>Cer</i>	rtment of tificate of	Health an Death	d Mental I	Hygie Reg.		1115	20365
		Decedent's Name (First, Middle, Last)					2. Date o		Day	Year	3. Time of Death
Physicia /Medic		Paul Lincoln Mine	r				Jun	2	26	docto	1700 AM
Examin		4a. Facility Name (If not institution, give street			/-	or Location of D	Death		4c. County		
		Union Memorial Ho 5. Social Security Number 6. Sex	*	h i ab do)	Ba1	timore	Hrs G Date o	4 Clab		N/A	(0)
Funeral Director		480-01-9277	7. Age (In yrs. last	Yrs.	Months Days		Hrs. 8. Date o Min. (Month March	Day Ye	ar) 1918	Counti	
	1	Usual Residence of Decedent					rator	,		1 1011	<u> </u>
aryland •how		10a. State 10b. County	10c. City, To	own or Loc	cation					10	d. Inside City Limits
e Ma	cto	Maryland N/A		Balti	more						1 X Yes 2 □ No
ih th or 26	Director	10e. Street and Number			10f. Zip Code	04.0		10g.		What Counti	ry?
eth w	ral	4100 North Charles S		T 40 11		218	0/0 // //		US		
ttem Treer	Funeral	A	as Decedent Ever in U.S. med Forces?	13. V	Yas Decedent of Yes, specify Cu	ban, Mexican, F	? (Specify Yes o Puerto Rican, etc.))		ce - America ick, White, e	
urs after deeth with the Maryla at, or tema 23a or 28a-f ehov Examinar must be notified at	by	3 Widowed 4 Divorced	MYes 2□No 1942 Yes, Give ear or Dates: 1946	1	☐ Yes 21X No	Specify:			Specif	か: Whi	te
		15. Decedent's Education	1. 10	6a. Deced	ent's Usual Occi	pation	funding	166	. Kind of B	Business/Indu	ustry
thin 7	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)		kind of work done OO NOT use retir	ed)	working				
be filed within 72 ho ital Hygiene. id other then "natu	Con		4	Broa	dcaster	45 44 15 4				lverti	sing
be fill Hall H	Be	17. Father's Name (First, Middle, Last) Sydney Miner					Name (First, Mic V Pfiest		den Sumar	ne)	
should be nd Mental marked c	ဥ	19a. Informant's Name/Relationship (Type, P.	oint) 1	9h Mailin	n Address (Stree		y Filest or Rural Route Ni		ty or Town	State Zin (Code)
d 2 s Ith an E7 le		Antonia Miner / Wife			•						land 21218
Health Health tom 27 other tr		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of natory or other pl	nal Les	Date			- City or Tow	
Pages nent of int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al Irom State	_	ematory		6/27/06	Ba	1time	re M	aryland
교 된 된 글 .		21. Signaturetot Funeral Service Licensee	11.002			ress of Facility	ty Of Ma	- Da	nd In	7EC 9 1 R	aryrana
Depermine only in the party in		Thomas Gregor		2	99 Fred	erick R	oad Balt	ingra	e, Ma	ic. irylan	d 2 12 28
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. Duse on each line.	o not ente	er the mode of dy	ing, such as ca	rdiac or respirato	ry arrest,	_		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cordu	ON	My	224	Here's	+			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of :	1-01		-11/1	00		*	20100
LAdminer	_	Sequentially list conditions, b. —	Due to (or as a consequence	NA	1114	en	OX Su	NK.		- 4	12200
ted nslt	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	150	5 //	P						
be executed ician and burial-transit	Examiner	that initiated events c	Due to (or as a consequent	ce of):							
cate be executed only sician and the burial-transit	dicai										
ng ph	Med	IF FEMALE:					-		1		
eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal dea	ath 3 🗆	Ectopic pregnan	су				ate of deliver	y Day Year
the at	Physician/Med	1 Type 2 No	□Pregnant at time of death □Unknown	5 □	Other (specify)			_			July 10a
by th		Part II. Other significant conditions contribute	ting to death but not resultin	g in the ur	nderlying cause o	ven in Part I.	23e. I	Did tobacc	co use con	tribute to the	cause of death?
uires tha signed Id be del	d by							I □ Yes	2 🗆 No	3 Proba	bly 4 □Unknown
w requir been s	iete						24a. \	Mas an	24b.	Were autop	sy findings available
The law	Completed						- 1□ Y	erformed	1?	prior to com death?	pletion of cause of 2□ No
	0	25. Was case referred to medical				26. Place of	Death (Check o		440	10165 2	2 140
Physicl Physicl this cer at direc	To B	examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 DEA	Outpatien	t 3□ DOA O	ther: 4 🗆 Nursi	ng Home 5 🗆 i	Residence	6 □Oth	her (Specity)	
ding Pl b. After ti		27. Manner of Death 1 □Matural 5 □ Pending	a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Inj W		28d. Descr	ribe how i	njury occur	rred	
tendi leath. tor: A	cati	2 Accident investigation				Tes 2 No		(0)			
or At after of Direction by	Certification:	4 Homicide determined 28	 Place of Injury - At home building, etc. (Specify) 	, tarm, stre	eet, factory, office	•	City of	on (Street r Town, S	tate)	ber or Hurai .	Route Number,
spital ours sours and filled		29a. Certifier 1 Certifying Physician	1: To the best of my knowled	dge, death	occurred at the	time, date and t	place, and due to	the cause	e(s) and m	anner as sta	ted.
To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: After this certifical completely filled in by the funeral director; to	edical	(Check only 2 Medical Examiner: (On the basis of examination and manner stated.	and/or inv	estigation, in my	opinion, death	occurred at the ti	me, date	and place,	and due to t	the cause(s)
To th within To th comp	Me	29b. Signature and title of Certifier			29c. Licer	nse number	2-0	29d.	Date signe	Month, D	ay, Year)
VI		* X II SELL	M)		()	111	37	0	27	106	
Dan		30. Name and address of person who comple	ted, cause of death (Item 23	a) (Type,	Print)	20 9	33-4	5	Bul	DIAM	e, MD
Sta	to	31. Date filed (Months (Pays) 2000	3 Registrar's Signature	IVI	<i>y</i> 30	10 0	/ /		1111	- Al Ann	11111
Registr		31. Date filed (Many) Pay2 9 2006	Mayer S.	Apa							

06-04438 Hugh Melver

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2	1	# 1	Fac.	2		<	Sug	20
Emm	2	1	2	100	U	13	13	À,

	1- For State Registrar		Certificate o	f Death			g. No.	J5 2035
Physician/ ledical Examine	Decedent's Name (First, Middle)					2. Date of Deat Month June 25, 2	Day Year 2006	3. Time of Death 0057 hrs
1	4a. Facility Name (if not institution Bon Secour Hospital			4b. City, Town, or L Baltimore			4c. County of Dea	
/ Juneral Director	5. Social Security Number 215–30–5326	6. Sex 7. Age (I	n yrs. last birthday)	Months Days	If Under 24Hrs Hours Min.		6, 1934 Fore	
w any	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Loc					10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Maryland N 10e. Street and Number	/A	Da	ltimore 10f. Zip Code	-	10	ng. Citizen of What Co	
with the l s 23a or e notifie		treet 12. Was Decedent Ev	rer in U.S. 13. V	21223	anic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	erican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f sh. Examiner must be notified at once and by Furneral Director	3 Widowed 4 Div	Armed Forces? 1 Yes 2 X orced If Yes, Give Yeer	No	Yes, specify Cuban, Yes 2 X No		Rican, etc.)	White, etc.	hite
"natural" Examine		cify only highest grade completed College (1-4 or 5+)	during	ent's Usual Occupation most of working life. I			16b. Kind of Business	s/Industry
215-0036 be filed within 72 hour nuts! Hygiene, rked other than "natuent, the Medical Example Compuleted	12			orer			Warehous	e
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 12 is marked other than umatic event, the Medic		•		11		ed Otto	Maiden Surname)	
고 글 용 를 하 l c	2 19a. Informant's Name/Relations Sherry Lynn G			-			ober, City or Town, Sta 1 and 20794	
_ 2 % % 6	20a. Method of Disposition	3 Removal from State	20b. Place of Disp crematory or	osition (Name of cem other place)	etery,	Date	20c. Location - City of	or Town, State
를 를 ^교 로 능	4 Donation 5 Other Sc	necify:	Metro Cr	ematory Ir		29/06		e, Maryland
	21. Signature of Funeral Service Thomas Gregor 23a. Part I. Enter the disease, or	Thomas Gry		remation 299 Freder	Society ick Roa	Of Mar d Balti	yland Inc.	land 21228 Approximate Interval
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.			such as cardiac o	r respiratory arr	est, shock, or neart	Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a consequ						
i de	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of):					
tecuted and - transit		Due to (or as a consequence)	uence of):					
5 E E	UNPENDED	x AMENDED 1 p		56 6–2 9– 0 6	v t		Lood Bair of della	
	past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at tin g Unknown	2	Fetal death 3 Dther (Specify)	Ectopic pregna	ancy	23d. Date of delive Month	Day Year
that the de led by the detached f			ut not resulting in the	underlying cause gi	ven in Part I.		bacco use contribute t	
of Vital Records, P.O. ng Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detaced.						1 Yes	an 24b. Were a	obably 4 Unknown autopsy findings available
ecor							rmed? death?	yes 2 No
Vital Rec ysician: The l	25. Was case referred to medica examiner?	Hannital:	O. d. ED/Outnotic		of Death (Check		Residence 6 Oth	OF.
n of Vil ding Physia L. After this funeral din		28a. Date of Injury (Month, Day, Year	2 ER/Outpatie	f Injury 28c. Injury	y at Work?		now injury occurred	er.
Division tal or Attendi ins after death. ral Director: A		stigation		1Yo	es 2 No	28f. Location (\$	Street and Number or F	Rural Route Number, City
Div spital or nours afte neral Di filled in	3 Suicide 6 Coul	rmined (Specify)				or Town, S		
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the standard or the standard		hysician: To the best of my k miner:On the basis of examin and manner stated.						
E M E 0	29b/Signature and title of certific			29c. License O.C.N			29d. Date signed (M June 25, 2006	lonth, Day,Year)
• 2	30. Name and address of person Laron Locke MD. A	who completed cause of dea		nn Street, Baltim	ore, MD 212	01		
-				,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 05 PM **Physician** 030TH 20.6 JANSFIELD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMORE NIA TOSPITAL It Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 M 2 KF 250.48.8552 - (1 Yrs. · 02.1934 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene.
ie marked other then "neture!, or iteme 23a or 28a-f show eurnatic event, The Madical Exeminer mant be notified at NIA Mb Baltimore 1 Yes 2 No Director 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 21201 Pennsylvania Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 Store
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Š Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Domestic NIA 12th grade permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if tene 27 ie marked
eny injury or other 12 18 Mother's Name /First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mansfield Sall Wilson ဥ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 5402 Avenue Consin Remmell Balto Frederica loude 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 07/07/06 Arbutus Memonal 4 ☐ Donation 5 ☐ Other (Specify) Name and Acquess of Facility
HIGHAN C. Stream EFYMENT Sentice 21212
1905 York Koad Baltimore MD 21212 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) 130 USM TULMONAN **Physician** /Medical Due to (or as a consequence ot) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ò in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by cate hes been signi page 2 should be SLT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No certificate 1 ☐ Yes Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After tnjury 1 Natural 5 🗀 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Coutd not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel [
completely filled To the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date tiled (Month, Pay, Year)

JUN 2 9 2006

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garle

PLACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#29d PER PHY. G856 6/29/06 WSD State of Maryland / Department of Health and Mental Hygiene () () () 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year AM 8:00 3 2006 Walter Matthews June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Battimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Road 815 Windington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 1 M 2 □ F 81 217-12-326 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21229 notphibood 208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Snipbuild + Drydock Welder 11+1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence H. Matthews mma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rd Baltimore Md 21239 hevin Matthe Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dune 24, 2006 Lansdowne 4 ☐ Donation 5 ☐ Other (Specify) Camebery Home 21. Signature of Funeral Service Meensee 22. Name and Address of Facility Chatman-Haris Funeral 5240 Paisterstown Rd Baltimore 21215 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lyn6 CATGROMA Due to (or as a consequence of): Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

/Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

10a. State

Md

Directo

Funeral

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Completed

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Examine

Medical Certification: To Be Completed by Physician/Medical

29b. Signature and title of

31. Date filed (North, Day,

0

30. Name and 1300

Funeral

Director

ir then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at

other

it of Heelth and Mental

or other

permit. Pages 1 Depertment of H Importent: If Ite eny Injury or ot 2005

Physician

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy r (specify)	23d. Date of delivery Month Day Year
•	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
TRAGATE C	Armount	-	1 ☐ Yes 2 ☐ No 3 € Probably 4 ☐ Unknown
TRAGATE C	non		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death (0	Check only one)
examiner? 1 ☐ Yes 2 ♣No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing Home	5 Sesidence 6 □Other (Specify)
27. Manner of Death Salatural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ctory, office 281	Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occu aminar: On the basis of examination and/or investig and manner stated.		
29h Stonauxe and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

6-23-06

State Registrar ddress of person who completed cause of death (Item 23a) (Type, Print)

マンフィア

9-2006

700

Registrar's Signature

			1 - For State Registrar	State of Marylan		artment of tificate o			Reg	ene ()]6	20369
	Physicia	an	Decedent's Name (First, Middle, Last					M	ate of Death	Day	Year	3. Time of Death
1	/Medic			LR160		4h Cib. Taua	and position of	Dooth	6	4c. County	of Death	0356 AM
1	Examin	er	4a. Facility Name (If not institution, give			SILVE	or Location of	RINC				DMERY
	Funeval		HOLY CROSS 5. Social Security Number 6. Se	7. Age (In vrs.	last birthday)	If Under 1 Ye	ar If Under 2	4 Hrs. 8. Da	ate of Birth			lace (State or Foreign
	Funeral Director		none 1	□M 2 X F	Yrs.	Months Day	s Hours	S O	fonth, Day, \	006		ZYLAND
	D.		Usual Residence of Decedent	10.00	. T						11	Od. Inside City Limits
	arylar show	_	10a. State 10b. County		y, Town or Lo	_					- '	1 Yes 2 □ No
	he M	ecto	MD MONTG	OMERY SI	LVE	R SPR		·	100	g. Citizen of V	Vhat Coun	itry?
	with the or the	흐		DLE PINE T	ERR		904			USP		
	hours after death with the Maryland turel; or iteme 23e or 28e-f show at Examinet must be multiked at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.		Was Decedent of f Yes, specify C		in? (Specify Y		14. Rac	e - Americ	
(0	or iter	Ξ	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No				Puerto Rican	, etc.)		k, White,	
8	rel', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2X	lo Specify:			Specify	ISL	ACK
21215-0036	22 23	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Oct kind of work do	ne durina most (of working	16	6b. Kind of Bu	isiness/Inc	lustry
121	within ene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use ret	ігва)					
	filed v I Hygie other t		none 17. Father's Name (First, Middle, Last)	none	no	ne	18. Mother	's Name (Firs		none aiden Sumam	10)	
an(To Be	UANTHAN	ORRIGO			RICSI	TAN	011	RRICO	11 10	LEYE
Maryland	d 2 should be th and Menta It is marked treumatic ex	F	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stre					-	
	C = 01 L	n j	HOLY CROSS	HOSPITAL	150	O FOR	LEST C	LEN	RD S	SILVER	SPRI	ING MD 20910
Je,	es 1 and of Healt fitem 2 r other	1 3	20a. Method of Disposition		lace of Disponentery, crer	sition (Name of matory or other p	olace)	Date	20	Oc. Location -	City or To	wn, State
E			1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	in state								
Baltimore,	permit. Pag Department Importent: I eny injury c		21. Signature of Junera Service Licent On 1d S	Wade Virecton		Ate Ana 11timore	_	ard 65 21201	5 W. I	3al ti mo	ore S	treet
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the deat					piratory arres	st,		Approximate Interval Between
	Physician		Immediate C use (Final disease or condition	PREMA	TUR	174						Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):				3.	4		
	Examiner		Sequentially list conditions,	b. PRETE		LAB	200	COMP	, LI CA	1017	15	
	be is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a conseq	uence or):							
	and and II-tran	xan	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):							
8760	icate be executed physician and s the burial-transit		L.	d								
687	ficate g phys	edic		- U.								
ŏ	eath certific attending p I for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		∃Ectopic pregna	nev				e of delive	
m	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (specify				Mo	nth	Day Year
P.0	at the by th	lys	9 ☐ Unknown			-			na Didash	- 10	-16	an annual of dentile?
Records, I	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significent conditions of	ontributing to death but not res	ulting in the u	nderlying cause	given in Part I.	(: 2 No	3 ☐ Prob	ne cause of death?
ပ္ပ	aw requir as been si 2 should	Completed						2	24a. Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of
æ	The lav	E O						1	perform	ed?	death?	2 No
Vital		Bec	25. Was case referred to medical examiner?					of Death (Che	eck only one)		
of <	Physicien: this certific ral director,	2	1 ☐ Yes 2 No		ER/Outpatier	IL 3 DOA		sing Home				1)
0	ing P Viter t unera	on:	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Work?		Jescribe hov	v injury occuri	red	
Sio	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not b	9 28- Place of Injuny . At h	omo farm et		Yes 2 N		ocation (Stre	et and Numb	er or Rura	I Route Number,
Division	or Al after of Direction by	Certification;	4 Homicide determined	building, etc. (Special	(y)	eet, factory, on	Ce	202	city or Town,	State)		, , , , , , , , , , , , , , , , , , , ,
J	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Pt (Check only one)	sysicien: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in n	e time, date and ny opinion, death	d place, and d h occurred at	ue to the cat the time, dat	use(s) and ma e and place,	inner as st and due to	ated. the cause(s)
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7			30. Name and address of person who	completed cause of death (Itel	n 23a) (Type.		V 737	0 0		- (2	~ ~ ~ ~	
17,			KIMBERLY S	MOSS 1221		CANTI	E IN	LAR	00	MD	201	774
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death nt's Name (First, Middle, Last) Month Day Z Year **Physician** hav Unc /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 419 OUL _ 101V If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 □ F Director 028-36-3686 60 9,1945 Massachusetts Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County treumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena Maryland Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 8216 Old Mill Road 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Ship Captain Merchant Marine 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Trask Charles 0. Pillsbury Elizabeth 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3472 Old Crown Drive Pasadena, Maryland 21122 Gwen E. Rocco (Daughter) Department of Health Important: If Item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition remetery, cremetory or other place) North Beverly Cemetery 1 Burial 2 Cremation 3 Removal from State 6/29/06 Beverly Massachusetts 4 □ Donation 5 □ Other (Specify) 21. Signature of Funetal Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner attending physician end for use es the burief-trensit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 10 1 U Yus 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this nours efter death.

nerel Director: After this y filled in by the funeral d 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending investigation 2 No 1 Tes 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funerel C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause 69V 31. Date filed (Month, Day, Year) 27045 32. Redistrar's Signature State

Registrar

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	•	For State Registrar	State of Maryland		irtmen <i>tificat</i>				giene ["] Reg. No.	2006	203/
Di		1. Decedent's Name (First, Middle, Last,						2. Date of De Month	ath Day	Yeer	3. Time of Death
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H		30. Name and address of person who of the state of the st	completed cause of death (Iter	п 23a) (Туре,	Print) درم	C	1. D.	12-	e., -/-	, forn,	WH 2/13
9	ate	31. Date filed (Month, Day, Year)	Registrar's Sign	ature	M -	*		/			
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State of Maryland / Department of Health and Mental Hygiene 2 [11] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 7006 0337 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Hymore of Bultimore Ba N/A STRAT If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year | Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ **X**/1 2 □ F 214-14-5083 **New York** Director 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Maryland N/A **Baltimore** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2926 Rockrose Avenue 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 DX(es 2 DNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1945 Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify: Specify **Black** þ 3 □XVidowed 4 □ Divorced 1947 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Weirheimer, Inc. Machinist Mate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bedelia Payton Alonzo Payton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 West Belvedere Avenue Baltimore, Maryland 21215 Darryl Payton Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Suriai 2 □ Cremation 3 □ Removal from State 07/03/06 Owings Mills, Md. 4 □ Donation 5 □ Other (Specify) Garrison Forest Veterans Cemetery 21. Sign vire if Funeral Service Lice ee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Athensclentic /Medical Examiner sertensim Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a nonsecuence of Examiner -transit (erebnyascular physicien ar s the burial-t Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate hes been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner?
1 Property 1 No funeral director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After Division 5 Pending investigation Injury of or Attending of the death.

Director: All in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50500 who completed cause of death (Item 23a) (Type, Print) nd address of person KOTZER HIMMA 01 GREENE STREET SATTIMONE, MARYLAND 2/201 32. Mistrar's Signature State 2006 Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 1 6 20373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day June 25, Loretta O. Pattison 2006 7:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year Aug. 28, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔼 F Director Yrs 1918 Washington DC 578-16-5726 87 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane Apt9T03 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ANo à Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education or other treumetic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Importent: If item 27 is marked oth any Injury or other treumetic event QNCS. 18. Mother's Name (First, Middle, Maiden Surname) James Francis Oakley Angela McCaffery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug Pattison 842 Clarendon Lane, Aurora, Illinois 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 6/28/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Furtilal Service Licensee 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD23a. Part1. Enter the disease, or coopercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrilly tim trial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and ched for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Moo 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached t P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes To the Hospitel or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 12 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A completely filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jun 26 2001 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) March Chou lang 32. Registrar's Shaature 31. Date filed (Month, Day, Year)
JUN 2 9 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 5 20374 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kogers Month Physician Year 06 20 AM pracie 24, 2006 Junt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Hopkins Bayriew Care Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 242-46-1161 1 ☐ M 2 😿 F Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. The Middical Examiner must be notified at 1 os 2 No Director timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funerai Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) kind of work done during most of working 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "ni Coltege (1-4or 5+) Elementan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Rogers Informant's ame/R inship (Type, Print) 19b. Mailing Address (Street and Number or Accal Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum. Backo MD 21239 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Oaklawn Cemeter 630-06 Bayto MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Volume of long of Fatherine Francial Services M01363 0 Balto MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Arrhythmia
Dip to (or as a consequence of): Pnysician minutes disease or condition resulting in death) /Medical Examiner Hypoxia

Due For as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Chronic Repiratory P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial re Pulmonury Disease Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? failure, coronary 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 No Division of Vital 1 Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗀 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital
within 24 hours a
To the Funeral E

State Registrar 29b. Signature and title of certifier

30. Name and address of person who say leted cause of death (Item 23a) (Type, Print)

Greenaus

'9'

DHMH 17 Rev 1/2001

ORIGINAL

5505

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)
June 26, 2006

Hopkins Bayriew Circle Baltimore Maryland 21224

		_1	For State Registrar		State of Ma	•	epartm Certific				Re	3. No.	16	20375
	Physicia /Medic	n	1. Decedent's Name (F	irst, Middle, Last)	GEORGI	ECARL	RUBY				Date of Death Month une 2	Day 5, 200		3. Time of Death
	Examin		4a. Facility Name (If no. 319 Woo	institution, give stodland F	reet and number) Coad			Pasa				4c. County o	Aru	
	Funeral Director		5. Social Security Numb 212-30-58	24	7. Age M 2□F	(In yrs. last birti	rs. If Ur	der 1 Year hs Days	If Under 24 Hours	Min. N	Date of Birth (Month, Day, lar 7,	1933	Coun	lace (State or Foreign try) ryland
	laryland show			b. County Anne Ar	unde1	10c. City, Town	or Location		Pasa	adena			1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N a or 28a-f	Direct	10e. Street and Numbe	319 W	oodland	Rd.,	10f.	Zip Code	21122	2	1	g. Citizen of W	hat Coun	itry?
36	d within 72 hours after death with the Maryland jaens r then "naturel", or Items 23a or 28a-f show The Madical Examinat must be natified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	2. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			s 2 🔀 No	lispanic Origi an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		, White,	an Indian, etc.
21215-0036	within ane. then	Completed	(Specify (Sp	Decedent's Educ only highest grade ary (0-12)	ation completed) College (1-4or 5		`life. DO NO	work done	during most (d)	of working	1	6b. Kind of Bus		dustry
land 2	be file tal Hyg d othe event,	To Be Co	17. Father's Name (Fire	st, Middle, Last)	Car1		Ru	bу		's Name <i>(Fi</i> OSEMA		aiden Sumame Mi	tch	e11
Maryland	12 hal		19a. Informant's Name Thoresa			19b.						city or Town, S adena,		Code) . 21122
Baltimore,	of He		20a. Method of Dispos	ition Cremation 3 🗆 Re	moval from State		y, crematory	or other plac	-	Date . 6/2		oc. Location - 0		ie, Md.
Baltir	permit. Pag Department Importent:: any injury c		21. Signature of Suner		·Kevin		r 22. Nam M c C	and Addre	ss of Facility Polvi	niak	Funer	al Hom	ie.	P.A.
	bhysician hysician and hysician and hysician into burial-transit	Examiner	23a. Pant 1. Enter the shock, or heart fall immediate Cause (full falsease or condition resulting in death) Sequentially list condition fany, leeding to immediate. Enter Underlyt Cause (Disease or injurtat initiated events resulting in death) Las	tions, only on the state of the	Due to (or as	the death. Do ne.	Dero Obs	tic tru	110	art		SC AS	ens	Approximate Interval Between Onset and Death
68760,	at A	dical		La										
Box	ne death cer the attendir hed for use	Physiclan/Me	IF FEMALE: 23b. Was decedent print the past 12 months and 1 □ Yes 2 □ N 9 □ Unknown	egnant onths?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ic pregnancy (specify)	y	· · · · · · · · · · · · · · · · · · ·		23d. Date Mon		ery Day Year
ds, P.O.	luires that the signed by all be detacted	þ	Part II. Other significa	nt conditions con	tributing to death b	ut not resulting ir	the underly	ng cause giv	ven in Part I.				bute to th	ne cause of death?
of Vital Records,		Completed									24a. Was ar autopsy perform 1 Yes 2	ed? d	rior to cor eath?	psy findings available mpletion of cause of 200 No
Vita	Physician: The this certificate har director, page	To Be	25. Was case referred examiner? 1 X Yes 2 □ No.	1	ospital:	ent 2 ER/Ou	tpatient 3[DOA Oth		The state of the s	theck onlone	nce 6 Othe	or (Specif	(y)
	nding Physith. Ith.: After this funeral di		27. Manner of Death	5 Pending investigation	28a. Date of Inju (Month, Da	ry y Year) 28b. 1	Time of njury M	28c. Injui Wo	ry at	28d		w injury occurre		
Division	al or Attending s after death. I Director; After ed in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	ırm, street, fa	ctory, office		28f.	Location (Str City or Town		er or Rura	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director; After completely filled in by the funer	Medical (29a. Certifier 1 (Check only 2) one)	Certifying Phys	ician: To the best ner: On the basis o and manner st	f examination an	e, death occu d/or investig	rred at the ti	me, date and opinion, deat	d place, and th occurred	at the time, da	te and place, a	nd due to	o the cause(s)
	To the within to the comp	×	29b. Signature and titl	e of certifier	D.	Dep	NAY	$D\mathcal{O}$		54		d. Date signed		
1	l		30. Name and addres	s of person who co	mpleted cause of o	s, MI	(Type, Print)	,95	Am	eri	cr	210	35	
	St Regist		31. Date filed (Month,	Day, Year) N 2 9 200	32 Aegistr	ar's Signature	Cores		V .					

			For State	State of Maryland / D	epartment of H			ZUUD	20376
	-\$ \$		Registrar 1. Decedent's Name (First, Middle, Last)		Definicate of t	Jeani	Reg. I	10.	3. Time of Death
	- Physicia		Richard	Thomas			,Month [Day Year	· wire Ou
7 9	/Medic Examin	44.1	4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or	Location of Death	1	4c. County of Deal	
* 1	- Autim	. 2	Lovien Nursi	of Honer	Lole	imbic		How	and
	Funeral Director		5. Social Security Number 6. Sex 219 22 4780	14 000	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea OCT 28	9. Bin 927 M	thplace (State or Foreign buntry)
	ס		Usual Residence of Decedent	10.00					101 1-11 01-11
	arylar ahow	_	mb Howr	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 🏋 No
	he M	Director	M D HOW F	1120 375	ESVILLE 10f. Zip Code		100	Citizen of What Co	•
	with with			ian Hill Dziv		184	1.09.	115A	,
	death me 23	Funeral	.,,	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race · Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f ahow any follury or other traumatic event, the Medical Examinating matter indified at ance.	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No 1715	If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Hican, etc.)	Black, Whit	hite
21215-0036	2 hou	ted	15. Decedent's Educ	cation 16a. C	Decedent's Usual Occup	ation	16b	. Kind of Business	/Industry
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	1)	1.	1000.10	11-1-1
2	ed will ygien yer thi	Completed	12	4 Se	non Mech			lesting.	House
Maryland	ntal H ed off	Be	17. Father's Name (First, Middle, Last)	omas		_	e (First, Middle, Maid Louise S		phas
2	should nd Mer marke imarke	ဥ	19a. Informant's Name/Relationship (Ty)		Mailing Address (Street				
	and 2 salth ar n 27 la		Julia Colonna T	Thomas WIFE 12	575 INDI	AN HILL	OR 34KG	SVILLE 1	no 21784
č.	of Hear		20a. Method of Disposition	20b. Place of l	Disposition (Name of v, crematory or other place			Location - City or	
altimore,	Pages nent of ent: If it ury or o		1 ABurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State GARRISO	· Forest Vet.	Cem. 7/5/	1200 6 OU	MGSMIL	
Balt	permit. Departr Importa any inju		21. Signature of Puneral Service License	Sun	22. Name and Addre		ZUMBNU F		
			23a. Fart1. Brite the disease or compli shock, or heart failure. List only or	ications that caused the death. Do no				0	Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition		o cadial	inform to	m		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	nf):	V			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a nonsequence of	0				
A	cuted	Examiner	that initiated events						
8760;	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of	f):				
387	physicate by the b	dlcal		f					
Box 6	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of de	livery
Ö.	law requires that the death certifit as been signed by the attending I 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1⊡Live birth 2 □ Fetal death 4□ Pregnant at time of death 9□ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _		<u></u>	Month	Day Year
P.O.	hat the	Phy	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause giv	en in Part I	23e. Did tobaco	o use contribute to	the cause of death?
Vital Records,	puires tha n signed ald be det							1	robably 4 □Unknown
CO	s been si	Completed					24a. Was an	24b. Were a	utopsy findings available
æ	The te h	шо					autopsy performed	2 death?	completion of cause of
ita	Physicien: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
ž V	Z v D	ပ္	1 ☐ Yes 2 No	fospital: 1 ☐ Inpatient 2 ☐ ER/Out		4 Nursing H	ome 5 Residence		ocify)
Division of	ding P	lon:	27. Manner of Death Natural 5 Pending	28a. Date of Injury 28b. Ti (Month, Day Year) In	njury ∣ Wor	yat k? Yes 2 □ No	28d. Describe how in	ijury occurred	
isio	Attending r death.	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fare		163 2 110	28f. Location (Street	and Number or R	ural Route Number,
<u>≥</u>	al or A s after il Dire	Certification:	4 Homicide	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	ate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier Certifying Phy (Check only one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	, death occurred at the tir Vor investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	within 2. To the To the Complet	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Mont	
	1		Kann	MD	1	005370	9	6/29/	٠ (
	1441		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)	c 210	Bowle mx	202	15
4.5		ite	RAJK CHAWLA 193 31. Date filed (Month, Day, Year) JUN 2 9 200	32 degistrar's Signature	South !	<u> </u>		2071	J
83	Regist	ar	00172 3 200	- Marine 10.	The state of the s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1 PER PHY: #200 PER FH G856 6/29/06 WS

ASiate of Manyland / Department of Health and Mental Hygiene

1- State Amend item#17,18, per H1,0857, //10/06 Tentificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death LEROY THOMAS Month Year **Physician** 23 5:33 A- M 2006 June 10mas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 84. A4hes Hospital NA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10X M 2□ F Vrs 216-20-8320 18 Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be notified an once. 1 ¥Yes 2 □ No Director MD NA altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code DRIVE 2100 3120 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer Bethlehem Geade NA 17. Father's Name (First, Middle, Last)
Timothy Wilson 18. Mother's Name (First, Middle, Maiden Sumame)
Redessa Jordan Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 2130 DR, Dalton 0600 1homas 61015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State lowing Mills, MD 21229 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 6/28/06 22 Name and Address of Facility ene Funeral 32 212 Valida Chiere Nath Pike Paltimore, MD 2126 5151 Baltimore Nath Pike Paltimore, MD 2126 21. Signature of Funeral Service Licensee Freene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latitude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pleural effusion Due to (or as a consequence of): **Physician** 1. Smooth /Medical Examiner 1. 5 mouth metastate non-small lung eaver noung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsician and e burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed anemia moust Due to (or as a consequence of): Box 68760, Completed by Physician/Medical unspecified attending physic for use as the b pheumoura IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death o 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No trokel 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2₽No Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ۵ 2 ER/Outpatient 3 DOA 5 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58571 06/23/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21229 MD Baltimore Tao 900 Caton Avenue Cullin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 9 2005 Registrar

			1 - For State Registrar	State of Maryla		ertificate of D			4 U U D	20378
			Decedent's Name (First, Middle, La	st)				Reg. It	40.	3. Time of Death
н	Physici		Joshua Ena	lebert Bron	to T	inkew			8 2006	100
	/Medic Examin		4a. Facility Name (If not institution, giv		1 4	4b. City, Town, or L			4c. County of Death	
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	Funeral		Social Security Number 6. S	Sex 7. Age (In yrs	. last birthday	If Under 1 Year				
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	pu ,		Usual Residence of Decedent	140-0						
	aryta ehov	ä	10a. State 10b. County		ity, Town or L				10	Od. Inside City Limits
	he M	Director	MD Anne Ar	undel	Seve		<u> </u>			1 ☐ Yes 2√ No
	a or	급				10f. Zip Code 2114		10g. C	Citizen of What Coun USA	ry?
	ne 23	Funerai	8212 Consett Cou	12. Was Decedent Ever in U	IS 13		panic Origin? (Specify Y	es or No-	14. Race - America	an Indian
	r iten	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		If Yes, specify Cuban,	Mexican, Puerto Rican,	etc.)	Black, White,	
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: b1	ack
9	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene 4 dether then "naturel", or iteme 23a or 28a-f ehow do other then "naturel", or iteme 20a or 28a-f ehow event, the Madical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra			edent's Usual Occupati		16b.	Kind of Business/Ind	ustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done du DO NOT use retired)	ring most or working			
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3	i Mer Marke marke	ဥ		nte Tink			Willa	Conn		
Maryland 21215-0036	12 st h end 7 te m Iraum		19a. Informant's Name/Relationship (Willa Connor/mot				d Number or Rural Rout	-		
e,	1 and Heeltl em 2; ther 1		20a. Method of Disposition		-	2 Conscionsion (Name of	Date		ern, MD	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Deparation of Heelih end Mental Hygiene. Intepartment of Heelih end Mental Hygiene. Inteparatist if time 27 is marked other then "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other place)	!	200.	Location - City or Tov	wh, State
臣	iit. Puritime		4 □ Donation 5 ☒ Other (Specify		1 2	2 Name and Addross	of Equility	- 2		
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	cate be executed physician and the burial-transit	Examiner	Cause (Diseese or injury that initiated events	c						
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9	ing pl	Med	IF FEMALE:							
Вох	death certific e attending p id for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta	ancy aldeath 3[Ectopic pregnancy			23d. Date of deliver	
o.	the deay the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o	death 5	Other (specify)			Month [Day Year
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							10	performed? Yes 2₩N	death? 1 ☐ Yes 2	₽No
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Division of	ding I h. After funer	盲	1 Natural 5 Pending	(Month, Jay Year)	Injury	Work?	- / 10	escribe how inju	W del	ver
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<u>S</u>	death death ctor: y the	<u>Ş</u>	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, st	re t factory office	39f. Lo	cation (Street a	and Number or Rural	Poute Num
	or Al	ertifica	3 Suicide 6 Could not be determined	building, etc. (Sp+)		re t, factory, office	alt. Lo	cation (Street a y or Town, Stat	and Number or Rural te)	Route Num e
	in State	al Certification;	4 Homicide determined 29a. Certifier 1 Certifying Ph	vsician: To the best of my kno	owledge, deat	h occurred at the time	date and place, and due	y or Town, Star	Col. M	M).
	in State		4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc. (Sp+)	owledge, deat	h occurred at the time	date and place, and due	y or Town, Star	Col. M	M).
	To the Hospital or Attan within 24 hours after dear To the Funeral Director completely filled in by the	Medical Certifica	4 Homicide determined 29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my known iner: On the basis of examina	owledge, deat	h occurred at the time	date and place, and due ion, death occurred at the	o to the cause(se time, date an	Col. M	ted. the cause(s)
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۲.	in State		29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	ysician: To the best of my known inner: On the basis of examina and manner stated.	owledge, deat ation and/or in Ulam n 23a) (Type,	h occurred at the time, vestigation, in my opin 29c. License n	date and place, and due ion, death occurred at the	o to the cause(se time, date an	s) and manner as stand place, and due to the	ted. the cause(s)
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ORIGINAL

			1 - For State	State of Marylai		ent of Health and atte of Death		120 00 00	203/9
		•	Registrar 1. Decedent's Name (First, Middle, Last		1	,	2. Date of Death		3. Time of Death
	Physici /Medic		Wayne Mic	THE .	itehead		June ;	Day Year	
	Examin	er	4a. Facility Name (If not institution, give	Medical	enter 46. Cit	y, Town, or Location of Deat	į.	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs		ler 1 Year If Under 24 Hrs		9. Bin	hplace (State or Foreign
	Director		X12-60-X7X/	(M 2□F 52	Yrs.	Jays Hours William	SEPTEMBER	6,1953 m	ARYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	a-feh	ctor	MARYLAND N/A		BALTIM	DRE C	174		1 Yes 2 No
	or 28	Directo	10e. Street and Number	· · · · · · · · · · · · · · · · · ·		Zip Code 21213	10g.	Citizen of What Co	ountry?
	ns 23s	Funeral	11. Marital Status	12. Was Decedent Ever in t			pecify Yes or No-	14. Race - Ame	nican Indian,
036	72 hours after deeth with the Maryland natural', or itema 23a or 28a-f ehow dical Examinat must be notilied at	δ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	/1973- 1□ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 🔀 No Specify:	to Rican, etc.)	Black, Whit	e, etc. LACK
2-0036	"natural"	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Us (Give kind of	work done during most of wo	rking 16b	. Kind of Business	Industry
121	within ene. then	Completed	Elementary/Secondary (0-12)	7 College (1-4or 5+)	life. DO NOT	use retired)	B	ALTIMO	RE CITY
Z 5	filed Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)	× 9/~	2770	18. Mother's Na	me (First, Middle, Maid		
yland	should be nd Mental marked o	ToE	WILL E.	WHITEH		JON		ROBER	
Maryi	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (T)			ISS (Street and Number or Ri		•	
	s 1 and f Heelth itam 27 other ti		20a. Method of Disposition	20b.	Place of Disposition (A cemetery, crematory of	lame of		Location - City or	
more,	8 = 5		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	RRISON FO		30/2006 OU	INGS MI	US, MARYLAND
Balti	permit. Par Depertmen Important: eny injury		21. Signature of Funeral Service Licens		22. Name	and Address of Facility H. BROWN N. FUCTON AY	JR. FUN	ERAL H	OME
	20 = 0		23a. Part1. Enter the disease, or comp	ications that caused the dea				RE,MD	2/2/7 Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			· · · · · · · · · · · · · · · · · ·		Interval Between Onset and Death
6.4	/Medical		disease or condition resulting in death)	Due to (or as a conse					Zangs
	Examiner		Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	railure	-			lyear
	nsit	Examiner	Cause (Disease or injury	Due to (or as a conse	quenca or):				
oʻ	te be executed ysicien and te buriat-transit	Еха	that initiated events resulting in death) Last	Due to (or as a conse	quence of);				
98760	licate be executed physicien and s the burial-transit	edical	(d					
_		/Mec	IF FEMALE:	t3c. If yes, outcome of pregr	ancy			23d. Date of de	ivery
Box	death certi e attending od for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 □Ectopic			Month	Day Year
д. О.	ires thet the de signed by the a f be detached f	Phys	9 Unknown	9□ Unknown			20 20111		
	law requires thet the as been signed by th 2 should be detache		Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	g cause given in Part I.	1 ☐ Yes		o the cause of death?
S	w require been sign	letec					24a. Was an	24b. Were au	itopsy findings available
Ke	The ta	Completed by					autopsy performed	prior to	completion of cause of
Vital Records,		BeC	25. Was case referred to medical examiner?				ath (Check only one)	12100	
5	Physic this c	ို	1 Yes 2 No		ER/Outpatient 3☐ I		fome 5 ☐ Residence		city)
<u>0</u>	th. : After s funera	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work?	200. 2000 100 100 1	nary occurred	
Division of	or Attending Physician: uter death. Director: Atter this certition in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		ory, office	28f. Location (Street City or Town, St		ıral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kn		and at the time, date and place	and due to the cause	a(s) and manner or	stated
	P Hos	Medical		ner: On the basis of examin and manner stated.					
	To the To the comp	ž	29b. Signature and title of certifier	1 0	2	29c. License number		Date signed (Mont	
1	\		Sugerre	(hephed	MD	M19827		ine 2	3,2006
	141		30. Name and address of person who o			e St. Baltin	nore, MI	21201	
	Sta		31. Date filed (Month, Day, Year)	32. Resistrar's Sign		K o			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 5 Certificate of Death 2. Date of Oeath 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** NOL 1914 JALTON JUNE 2006 /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL CENTER WES 5. Social Security Number 213-269082
Usual Residence of Decedent 8. Date of Birth 7. Age (In yrs. last birthday)
Yrs. 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 225F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "natural", or Items 23s or 28s-1 ehov treumatic event, it a Medical Examinar must be notified at 1 Xes 2 No **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 552 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married 2 **X**No 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) 17. Father's Name (First, Middle, Last) Be JKNOWN ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth Item 27 i Balto MD 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Ba OLOMA21234 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DECOMPENSTATED HEART FAILURF CONGESTIVE DAYC Due to (or as a consequence of): CARDIAC ARRYTHMIA SUPRAVENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ATHEROSCUE ROTIC CARDIOVASCOLAR DISEASE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown CERERROVA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ARCINOMA autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit P.O. Box 68760, ettending physician for use as the buria ed by the e Division of Vital Records, certificate has : After this certification, I death. within 24 hours efter death To the Funerel Director: / completely filled in by the f To the Hospital

ehow

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

State

4 Homicide

(Check only one)

29b. Signature and title of certifier

asanthalcuma.

29c. License number

Textifying Physician: To the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D42510

JUNE 19th 2006

and address of person who completed cause of death (ttem 23a) (Type, Print)

MD21201 407 M. VASAW 821. N. EUTAWST. NM

Registrar

31. Date filed (Month, Day, Year)
JUN 2 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [5] State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Day **Physician** 24, 2006 8:20 AM M Watkins, Sr. Raymond /Medical 4c. County of Death Anne Arundel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pasadena 8260 Riverside Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 2, 19 Birthplace (State or Foreign Country) **Funeral** 10M 20F 60 214-48-2206 Yrs 1946 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Tyes 2 DAG Maryland Anne Arundel Pasadena Directo 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8260 Riverside Drive 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Electrical Company Electrician permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if item 27 is marked othe any loung or other treumstic event ping. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E1va Μ. Michaels Watkins, Sr. Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Watkins (Wife) 8260 Riverside Drive Pasadena, Maryland 21122 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Loudon Park Cemetery 6/28/06 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility NCCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Mins 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma **Physician** Mouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 2 No 1 ☐ Yes 20**X**No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ဥ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After s after des. rai Director: Afte 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D 1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 28s Cortifier Medical (Check only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

D39505

305 Hospital or. Glan Burnie, MD. 21061

June 26, 2006

han M.D

32. Pogistrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Markon

JUN 2 9 2006

walkish

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

HINA GHAFOOR

JUN 2 9 2006

31. Date filed (Month, Day, Year)

m.0

32. Registrar's Signature

Division of Vital Records. P.O. Box 68760.

		For State Registrar	State of Maryland / [Department o			iene 006 20383
Physic /Medi		1. Decedent's Name (First, Middle, Last)	8try			2. Date of Deat Month June	Day Year
Examir		4a. Facility Name (If not institution, give si Genesis Homew	ood Center	Balt	m, or Location of Dea		4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 173-24-0724 Usual Residence of Decedent	M 20 F	rthday) If Under 1 Y Yrs. Months Da	ear If Under 24 Hrs ays Hours Min		9. Birthplace (State or Foreign Country) 1932 5. Carolina
Maryland B-f ahow	tor	10a. State 10b. County	10c. City, Tow Balt	m or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 430 6 Arizona	^	10f. Zip Co	de (O (φ	1	0g. Citizen of What Country?
ire, INIATY IZING ZIZIO-0050 s 1 and 2 should be filled within 72 hours after desth with the Maryland If Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28s-1 show other traumatic avent. Ite Medical Examitiser routibe notified at	þ	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 1 Yes 2	14. Race - American Indian, Black, White, etc. Specify:		
within 72 ho ane. than "naturi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use re 	one during most of wo etired)	orking	16b. Kind of Business/Industry Baltimore City
iry iand CIA thould be filed with d Mental Hygiene. marked other than matic avent, Itel	To Be Co	17. Father's Name (First, Middle, Last) Roy Nichols	(e yrs	Teachers		me (First, Middle, I	Public Schools Maiden Sumame)
ire, Midry s 1 and 2 sho if Health and N itam 27 is ma othar trauma		19a. Infamant's Name/Relationship (Type An it a Thomas 20a. Method of Disposition	Grand Daught	Mura St	cent Bal	r, City or Town, State, Zip Code) \rightarrow MD 21313 20c. Location - City or Town, State	
timo t. Page rtment o rtant: if rjury or		1 Surial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service □ onse	emoval from State	ary, crematory or other I Mem , Car	rdens 7/	7/06	Aberdien MD Harris Funeral Home
Depa Depa impo any ii	la 1	23a. Part1 Enter the disease, or complice speck, or heart failure. List only on	cations that caused the death. Do	5240 Reis	Sterstown	Bd Bo	Itimore Md 21215
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	Arkey	Diseas	R	Onset and Death
	Examiner	Sequentially list conditions if any, leading to immediate cause (Disease or injury that initiated events					
Certificate be executed ding physicien and use as the burial-transit	Ilcal Exa	resulting in death) Last					
SOX O ath certificather the certification of the ce	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 Ectopic pregr 5 Other (specif			23d. Date of delivery Month Day Year
S, T es that es that igned be deta	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying caus	e given in Part I.	23e. Did tol	bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
The law ate has b page 2 st	Completed					24a. Was a autops perfori	sy prior to completion of cause of
OT VITA Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA	Othor	eath (Check only on	ence 6 ☐ Other (Specify)
Jing After	h-	27. Manner of Death 1 Matural 5 Pending Accident investigation	28a. Date of Injury 28b.		Injury at Work?	-	ow injury occurred
or to Differ in b	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)			City or Town	
To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier (Check only one) 1 Cartifying Physical Examination (Check only one)	icien: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at t nd/or investigation, in	he time, date and plac my opinion, death occ	e, and due to the c curred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)
To th withir To th	Me	29b. Signature and title of centifier			icense number		29d. Date signed (Month, Day, Year)
2		30 Name and address of person who co	mpleted cause of death (Item 23a)		005942	۷ ک	June 28 2006 od Center
V	1	IN IN THE	hota /	-0-05.	5 HO	nound	all lanton

06-04435 Jennifer Young Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hygiene

ennifer foung	State of Maryland / Department of Health and Mental Hygiene 1- For State amend Item #16a&b, 19a&2certificate of Death 6/29/06 JH Reg. No. Reg. No.	2006 2038
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day	3. Time of Death 2024 hrs
4		County of Death
Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Social Security Number 15. Social Security Number 15. Social Security Number 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Date of Birth (MM/DD yrs.) 19. If Under 1 Year 19. If Under 24Hrs. 10. ID 10	7 Poreign Country) Jamaica
ow any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No n of What Country?
h the Maryland 3a or 28a-f sh otified at once	10e. Street and Number 1336 Meridene Drive 10f. Zip Code 21239	USA
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene nit. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Vidowed 4 Divorced in res. Give real or Dates:	4. Race - American Indian, Black, White, etc. pecify: Black
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene It! Fitem 27 is marked other than "natural other traumatic event, the <u>Medical Examin</u> To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) IZHORAGE Nurse 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hother and the properties of the properties	nd of Business/Industry me Health Care
21215-00 und be filed with Mental Hygien marked other cevent, the M	Zadick Turner Hilda	Irname) WNK
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene m 27 is marked other than aumatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City Melissa D. Ramial Cordova 1336 Mendene Drive Balto. N	
Baltimore, MD 21215-00. permit Pages I and 3 should be filed with Department of Health and Mental Hygene Important: If item 27 is marked other I injury or other traumatic event, the Me	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify. Woreland Memorial Of 07 04 Ba	
Baltimo permit Page Department of Important: injury or off	21 Signature of Funeral Service Licensee 22 Name and Address of Facility 23 Name and Address of Facility 24 Address of Facility 24 York RD Balto. MD 2	servico 21212
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of):	k, or heart Approximate Interval Between Onset and Death
her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ied nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
760, cate be execul physician and he burial - tra	UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	2 35. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy M 4 Pregnant at time of death 5 Other (Specify)	Date of delivery Ionth Day Year
ords, P.O. Bc w requires that the des is been signed by the 2 should be detached fo	1 Yes 2 🗸	se contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific its after death. 1a Director: After this certificate has been signed by the attending I led in by the funeral director, page 2 should be detached for use as it errification: To Be Completed by Physician/	24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital lysician: his certif director, o Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence	ce 6 Other
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2 ledical Certification: To Be Comp		
Division o spital or Attending hours after death, rifiled in by the fune Certification:	3 Suicide 6 Could not be determined Could not be Homicide 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and or Town, State)	d Number or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatif		
M A		ate signed (Month, Day, Year) 25, 2006
9	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	e 31. Date filed (Month, Day, Year) 32 Shtrar's Signature	
DHMH 17 Rev 1/2001		

			For State Registrar	State of Marylai		artment of F			iene eg. No.2006	20385		
15.00	Physici	an	Decedent's Name (First, Middle, Last)	THELMA T.	YANKE			2. Date of Deat Month June 28	th Day Year	3. Time of Death 1:30 A M		
5.2	/Medic Examin	. 4	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Dea		4c. County of Dea			
1		40	1104 Elmridge Av 5. Social Security Number 6. Sex		. last birthday)	Balti If Under 1 Year		S Q Doto of Bigh	N/A			
	Funeral Director			M 2xF 80	Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Oct 27, 1925 Maryland						
	pug &		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	ocation		- 005 2.7	, 1/2/	10d. fnside City Limits		
	Maryli fed	tor	Maryland N/A		.,,	Baltim	ore			1 Yes 2 No		
	hours after death with the Maryland ture!', or tteme 23a or 28a-f ehow at Exactiner must be notified at	Director	10e. Street and Number	lmridge Aven	10	10f. Zip Code	212		0g. Citizen of What C	ountry?		
	e 23a			2. Was Decedent Ever in t		W D			USA	to the discount of the discoun		
(0	ritter de	Funeral	11. Maritaf Status 1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh			
003	urel', a	by	3 A Widowed 4 □ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 ₺ No			Specify: [Mhite		
<u>.</u>	in 72 h	olete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Business			
212	filed within 72 Hygiene. other than "nal ent, Ina Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker			Housewife	& Mother		
Maryland 21215-0036	b d la la	Be	17. Father's Name (First, Middle, Last) $ ext{Lloyd}$	Sanders				ame (First, Middle, M aret Arii)				
ary le	2 should and Mer le marks eumatic	To			19b. Mailir	ng Address (Street			; City or Town, State,	Zip Code)		
	and 2 salth a n 27 le		19a. Informant's Name/Relationship (Tyr. Bonita A. McLaughl		_ 1107	AAT - AAT - AAT - A	e Ave.,	Baltimore	, Maryland	21229		
ore	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemetery, crer	sition (Name of matory or other pla	ce) 7/1	Date :	20c. Location - City o			
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ticense			11 Cemete 2. Name <i>a</i> nd Addre				, Maryland		
Ba	Departi Departi Importa any nji		1/1/2	- KCVIII II IIC	1	McCully-F 3204 Mour	olyniak Itain Rd	Funeral H , Pasader	Home, P.A.	21122		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ith. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death		
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	conges	thre	head	taila	IVE		Morders		
4.	Examiner			Schem	quence of):	ardio	myor	oathu		years		
2 do 1	P #	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):		///	1		122.50		
•	xecute and	Examiner	that initiated events c. resulting in death) Last	Due to Was a conse	quence of):				years			
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai E	€ d	diabet	es					years		
9	ertifica ding ph	/Med	IF FEMALE:	20 16						<i>V</i>		
. Box	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year		
P.O.	tithe d by the tached	hysi	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□ Unknown								
	w requires that s been signed to should be det	by	Part ff. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	ven in Part I.	23e. Did tob	oacco use contribute t	o the cause of death?		
50.0	w requirements	ieted	- Cray Paring	111701	100	ו) נשפים	9	24a. Was ar	7			
Vital Records,	The lande ite has sage 2	Completed						autops perform	prior to death?	utopsy findings available completion of cause of		
/ita	clan: ertifica ector, p	Be	25. Was case referred to medical examiner?					eath (Check only one				
6	Attending Physician: r death. ector: After this certification the funeral director, by the funeral director, it	: To	1 ☐ Yes 2 No	28a. Date of Injury	ER/Outpatien	I 3 DOA	ner: 4 ☐ Nursing		ence 6 Other (Spe	ocity)		
on	Attending death. ctor: Afte y the fune	atior	1 Naturaf 5 ☐ Pending investigation	(Month, Day Year)	fnjury	Wo	rk? Yes 2□No		,,			
Division of	l or Atte after de Directo J in by th	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At to building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (Sti City or Town	reet and Number or A	ural Route Number.		
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	O	29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death	occurred at the ti	me date and place	e and due to the ca	ause(s) and manner a	boteta a		
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	ppinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)		
	with com	2	29b. Signature and title of certifier	refl	e	29c. Licens	(//G)	25	9d. Date signed (Mon	th, Day, Year)		
ì	0	2	30. Mame and address of person who con	mpleted cause of death (fre	m 23a) (Type	Print)	711	<i>y</i>	100	0.0		
_	l		Reservation	M) 860	1 Vet	2/ans	High	way 20	y Mill	1.0 Day, Year) 1-06 1.15VI/PMT 21100		
447	Sta Registr		31. Date filed (Month, Day, Year)	32. Regionar's Sign	ature	Coule	,	/	1	2408		

20385 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 1853 2006 iere ANTONIA ACEVEDO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WAshin FORT WASHINGTON HOSPITAL root 3~ If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/14/1926 9. Birthplace (State or Foreign Country) EL SALVADOR 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 😭 F 30 Yrs. 577-29-6435 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at Yes 2□No Directo PRINCE GEORGE MD FORT WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 7505 EPPING AVE EL SALVADOR filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: EL SALVADOR 1 ¥Yes 2 □ No þ Specify: HISPANIC 3 ₩Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If liem 27 is marked oth any injury or other treumatic event ODGS. Be 2 PAULINO ACEVEDO ANTONIA RODRIGUEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 7505 Epping ave, Fort Washington, MD 20744 DAYSI JUAREZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State cementery Mount Offvet *4 □ Donation 5 □ Other (Specify) 06/10/2006 Washington, DC 23 Signature of Juneral Service and Address of Facility SANTA CRUZ SERVICIOS FUNERARIO. 600 Kennedy St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterosch entic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested in the cause). Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 dinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2. ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 304 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 4 2006 Registrar

			for State			State of M	aryland		artmen <i>rtificat</i>			d Me			4 4 0	5	2038/
			Regis		First, Middle, La	st)			incai	COIL	Jean	2.	Date of Dea	Reg. No	•		3. Time of Death
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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or frams 23a or 28e-f show raumatic event, the Medical Exerites must be natified at	Completed by Funeral Director		ever Married	2 Married	1 Yes 2 XIII If Yes, Give			res, spe 1⊠ Yes				vadori		Black, \		
Maryland 21215-0036	hou	ed		15	Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ition				ind of Busin		
15	in 72 " ne in lie	olet		(Specify	only highest gra	ide completed)	-	(Give	kind of wo DO NOT u	rk done d se retired)	uring most of	working					,
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ary.	should nd Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											Code)			
	nd 2 alith a 27 is		Jose Ventura/Brother 18015 Silver Leaf Rd. Gaithersburg, MD. 2											0877			
9	ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygliene. If item 27 is marked other than "netur or other traumatic event, the Medical			od of Dispos			20b. PI	ace of Dispo	sition (Nar	ne of	ə)	Date	9	20c. L	ocation - Cit	y or To	wn, State
Ë	Page ent o nt: If ry or				Cremation 3 ☐ ☐ Other (Specil	Removal from State v)		teno (3	-16-0	06	Lallı	nion.	E1	Salvador
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.				ral Service Licer		1 - 0 11				s of Facility M			Fur	neral	Hom	e
ä	Depar Impor any in		A Marshall, 4217 9th. St. N.W. Washington, D.C. 2									0011					
			23a. Part shoo	thenter the	disease, or com ailure. List only	plications that cause one cause on each I	d the death ine.	. Do not ent	er the mod	de of dying	g, such as car	diac or re	espiratory ar	rest.			Approximate Interval Between
	Physician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction												Onset and Death		
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ш	Examiner		Sequentia	ally list condi	tions.	b											
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Δ,	that the de ed by the detached	Ph	Part II. Oth	her significa	int conditions	contributing to death t	out not resu	Iting in the u	nderlyina c	ause dive	n in Part I.		23e. Did to	bacco	use contribu	te to th	e cause of death?
Records,	w requires that been signed be should be det	d by				J		J	, ,	3			1 🗆 Y	es 2	© No 3[] Proba	ably 4 Unknown
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3ec	4 5 C1	ldu											24a. Was autop		24b. Wer prior deat	e autor r to con	sy findings available apletion of cause of
	Th ate pag												1 ☐ Yes	2 X No	1 🗆	Yes	2□ No
of Vital	Physician: Th this certificate ral director, pag	Be	exami			Hospital:		7		Othe	26. Place of						
of	Phys this	: To		er of Death)	1 ☐ Inpati		ER/Outpatier 28b. Time o		20	4 1401311		5 Resid			Specify)
u C	ing After une	lon	1 🖎 Na	atural	5 Pending	(Month, Da	y Year)	28b. Time o	M. M	28c. Injury Work	? ′es 2 ⊡No	200	2. Describe ii	iow inju	y occurred		
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Division	in the	Certification:	4 □ H	Iomicide	determined	building, e	tc. (Specify)	eot, lactor	y, onice		200	City or Tow	m, State)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rioute rumber.
_	Hospital 4 hours Funeral tely filled		29a. Certi	ifier 1f	☑ Certifying Pt	nysicien: To the best	of my know	wiedae deati	n occurred	at the tim	e date and n	lace and	due to the o	ause(s	and manne	er as st	ated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical		ck only 2		niner: On the basis of and manner s	of examinat										
	To th within To th comp	Me	29b. Signa	ature and titl	e of certifier		1		290	c. License	number		- 1	29d. Da	te signed (A	fonth, L	Day, Year)
					DOY.	Kerel	1		1	D0983	34			06-	-09-06		
1	(1)		30. Name	and address	s of person who	completed cause of	death (Item	23а) (Туре,						00	07-00		
1	-6		Bar	ry N.	Rosenba	um 3720 F	arrag	ut Ave	enue l	Kensi	ngton,	MD.	2089	5			
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	Regist	ar		JUN 1	3 2006	Beach	N.	Break									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 5 2 U 3 8 8

		1 - For State Registrar		State of Me	il ylarid /		tificate of			Reg. No.		Sem O 1	4 7	
		Decedent's Name	(First, Middle, La:	st)					2. Date of De	eath Day	Year	3. Time of I		
Physi /Med		Laurens	Blaine	Aumen					June	13		8:30	РМ	
Exam		4a. Facility Name (If					4b. City, Town, o	r Location of Deat	h		County of Death			
				rial Hosp				derick			Frederick			
Funera	al	5. Social Security Nu	1	ex 7. Age ☑M 2☐F	e (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.	. (Month, D	ay, Year)		place (State or intry)	roreign	
Directo	r	217-30-58	80	****	71	113.			July 1	5, 19	34 Mar	yland		
and *		Usual Residence of I	10b. County		10c. City, T	own or Loc	ation					10d. Inside Cit	y Limits	
Aaryli Febo	٥	Maryland	Fr	ederick	F	'reder	ick					1 📉 Yes	2 No	
the N	Director	10e, Street and Num	ber				10f. Zip Code			10g. Citiz	en of What Cou	untry?		
death with the Maryland rms 23a or 28a-f ehow		2122	Carrol1	. Creek V	liew (Ct.	2	1702		Uni	ited St	tates		
leath	Funeral	11. Marital Status		12. Was Decedent			Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S	Specify Yes or N	0- 1	4. Race - Amer Black, White			
fler of	FUF	1 Never Marrie	d 2 Married	Armed Forces? 1 ☐ Yes 2 🔯	No		☐ Yes 2 🖾 No		no moan, etc.)			hite		
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within 72 hours after ene. then "natural", or ite	Completed	(Special	15. Decedent's E fy only highest gra	ducation ade completed)	1	6a. Deced	ent's Usual Occup kind of work done OO NOT use retire	ation during most of wo	orking	16b. Kin	d of Business/l	ndustry		
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aryia should and Men marke	٢	19a, Informant's Na			19b Mailin	g Address (Street			ber. City or	Town, State, Z	ip Code)			
I'E, MATYIANG ZIZIO-UUSO 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f ehow other traumatic event, the Medical Examinational has notified at			stine /			2122		L Creek V					702	
or Health a filter 27 is		Val Ago		IIIeliu	20b. Plac		sition (Name of natory or other pla		Date		cation - City or			
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Baltimor permit. Pages: Department of b Important: If its eny injury or of	ogo	Rout	mm D	soloni	= 1		621 Opos					21702	•	
		23a. Parti. Enter th	e disease, or com	plications that caused	the death. I							Approximate Interval Bety	e ween	
Dhunisia		shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Brain Sterm Nemonked the Sterm Ste												
Physicia /Medic	_	resulting in death)	•	a	a consequer				-			<u> </u>		
Examine	er			hus	retrac	2516	~					yea	24	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									•			
68760, tificate be executed of physicien and as the burial-transit	2	Cause (Disease or that initiated events	njury	c										
6 exe			ast	Due to (or as	a consequer	nce of):								
68760, ficate be ex physicien as the buria	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown 23d. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Version Female Version Ver												
Se as	1	IF FEMALE:		23c. If yes, outcome	of pregnanc	v					23d. Date of del	verv		
BOX death cert e ettending de for use a	1	23b. Was decedent in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnand Other (specify) _	ey .			Month	-	rear	
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cord: w require s been si should b		Ren	al ins	ulhience	4				24a. Ws		24b. Were au	topsy findings completion of c	available	
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Vital sician: T certificat rector, pi	(25. Was case refer		134 (1196)				26. Place of D	eath (Check only					
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ng Ph ter th		27. Manner of Deat	h 5 Pending	28a. Date of Inj (Month, Da	ury 20 ay Year)	Bb. Time of Injury	28c. Inju	ury at ork?	28d. Describe	e how injur	y occurred			
Division of a or Attending Phy effer death. Director: After this din by the funeral d		2 Accident	investigati	on			M 1]Yes 2 □No						
ivis r Atte fer de lirecte		27. Manner of Deat 1 Haratural 2 Accident 3 Suicide 4 Homicide	6 Could not determine	200. Flace UIII	ijury - At hom tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or T	(Street an own, State	d Number or Ri	<i>iral Route N</i> um	iber,	
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2												atata d		
Hosp 4 hou Fune ely fil		29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	Physician: To the besi aminer: On the basis of and manner s	of examinatio	edge, deat n and/or in	h occurred at the t vestigation, in my	opinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s	s)	
thin 2 the mple		one) 29b. Signature and	title of certifier	and mainer s	ialou.		29c. Licen	se number		29d. Dat	e signed (Mont	h, Day, Year)		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Ulife For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Thelma Corrine Ameling June 8, 2006 1:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8411 Brady Ave. Prince Georges Bowie 5. Social Security Number If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 21 F 90 Director 578-10-9587 2006 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. f Health and Mental Hygiene. Itam 27 Is marked other than "netural", or Items 23s or 28s-f show other traumatic svent, the Medical Exam and mark the confiled at 10c. City, Town or Location 10d. fnside City Limits 10b. County 1 ☑ Yes 2 ☐ No Director Prince Geroges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8411 Brady Ave. 20720 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo ff Yes, Give Year or Dates: 14. Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ft. Meade PX 12 Purchaser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine A. Brown Frank C. Brown, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: if Itam 27 Is any Injury or othar trau Kathy Edgel/ Niece 21412 Cooper Lane Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery6/10/2006 Brentwood, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Lice 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or comprehations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6/00 ancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 X No 1 ☐ Yes After this certific funeral director, Be 25. Was case reterred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 28a. Date of fnjury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Scott State JUN 14 Registrar

State of Maryland / Department of Health and Mental Hygiene / 13 Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav **Physician** June 13,2006 1:30p Paul E. Arbour, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ceci1 Elkton 47 Belle Hill Rd. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**√** M 2□ F Months Yrs. 89 Director 214-16-5907 May 10,1917 NJ Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show rai', or iteme 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director MD Cecil Elkton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 47 Belle Hill U.S.A. Rd. 21921 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after ☐Yes 2☐No Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced White Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Construction 11 Operating Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ă and Mental intment of Health and Menta intent: if Item 27 is marked njury or other treumatic ev ဂ္ Napolean Arbour Ethel Maurer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Feeder Rd., Elkton, Diane Hair/Daughter MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department importent: finportent: finportent: finportent: finportent: finportent: finportent outpury outp Elkton, MD 4 □ Donation 5 □ Other (Specify)
2 Signature of Superal Pervice Licensee Gilpin Manor June 16,2006 22. Name and Address of Facility
Andrew G. Gee Funeral Home ver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Elkton, Immediate Cause (Final unk **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Unle 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Schesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Certification; To safter dea... eai Director: After n... nv the funeral dr 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funeral C Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certi JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Pgint) 10 NNP MO 31. Date filed (Month, Day (Year) JUN 15 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State	State of Marylar		artment of H			giene <u>r</u> U U leg. No.	0 20391
			Registrar 1. Decedent's Name (First, Middle, Last	1)				2. Date of Dea	-	3. Time of Death
	Physicia	an	Charles A	inge				Month	17 200	6 1736 M
	/Medic		a. Facility Name (If not institution, give			4b City Town o	r Location of Deat		4c. County of	
	Examin	er	1. (= 1)	yland Medical	OMON	RIL	imore		NIA	
			5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs		n 9	. Birthplace (State or Foreign
	uneral		519-54-9762	x M 2□F 5		Months Days	Hours Min.		1949	Country) Idaho
U	irector		Usual Residence of Decedent							
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Mary	63	ō	MD Carrol	1	Wes	tminster				1 ☐ Yes 2 XNo
e s	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
with	Sa or	ā	907 Cindy Lane			2	1157			USA
leath	18 25 E	Funeral	11, Marital Status	12. Was Decedent Ever in U	J.S. 13. \	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-		American Indian,
fler	흔칅	Fun	1 ☐ Never Married 21 Married		9 / L	f Yes, specify Cuba		to Hican, etc.)		White, etc.
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be filed within 72 hours after death with the Maryland	od other than "nature!", or itame 23a or 28a-f show avent, tra Medical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)						Maiden Sumame)	
g g	rked tic a	P	Charles Alfred A	inge, sr			Ellen	Kangas		
2 should	Department of Heelin and Mental Hygerie. Important: If Item 27 le marked other than any Injury or other traumatic avent, Item Mi once.		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	r, City or Town, St.	ate, Zip Code)
and	19 T		Joan Ainge/wife		1	Cindy La		minster,		
- Se	r oth		20a. Method of Disposition 1	20b.	Place of Dispo cemetery, crer	sition (Name of matory or other pla	сө)	Date	20c. Location - Ci	ty or Town, State
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a a	3 = 3		John K. Ang	1	4	12 Washi	ngton Ro	ad Westr	minster,	MD 21157
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yeici	is cer direc	0	examiner? 1 ☐ Yes 2 🐪 No	Hospital: 1 patient 2] ER/Outpatie	nt 3 DOA Ott	ner: 4 Nursing	Home 5 ☐ Resid	dence 6 Other	(Specify)
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pspit	within 24 hours effer death. To the Funeral Diractor: Affer this certificate hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use			ysician: To the best of my kr						
he H	in 24 he Fi	edical	one)	and manner stated.	and and or in					
To ti	To t	ž	29b. Signature and title of certifier	111/		29c. Licens	se number		29d. Date signed ((Month, Day, Year)
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V	JET.	6	30 Name and address of person who		m 23a) (Type,	Print)	d	11.	C. 1/4	~: 2 × \
19	4104		Davie Co	Jasy, 22		Greene	04. R	effimate	IN (D)	21201
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1996 20342 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ADAMS Month **Physician** 1015 GRANVILLE 2016 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lintnicum

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sept. 17, Chesapeake Hospice House Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year)}1916 6 Sex 9. Birthplace (State or Foreign **Funeral** 1 M 200 Months 89 Yrs. 214-05-1745 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Southgate Avenue 21401 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 CNNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗗 No Specify: Specify. White 3XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Peges 1 and 2 should be filed v Department of Heelth and Mental Hygie Importent: if Item 27 is marked other the eny Injury or other traumatic event, tital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Granville Healy Carey Lee Meredith ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William K. Adams/son 732 Elliott Avenue Charlottesville, VA 22902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/12/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Euneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 07 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meta Physician 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4□Pregnant at time of death signed by the et d be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Frobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes : After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) + Ospace 1 Yes 2 No ဥ this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perse 31. Date filed (Month egistrar's Signature Registrar

		_	For State Registrar		Maryland	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a	and M		g. Nó:	06	200	4
	Physici		1. Decedent's Name (First, Middle, I								2. Date of Death Month JUNE	Day 14	Year	3. Time o	
	/Medic	al	EDWIN EARL AT 4a. Facility Name (If not institution, g		per)		4b. Citv.	Town, or	Location of	of Death	JUNE		2006 nty of Death	0:05	PM ^M
	Examin	er	WILLIAM HILL MA		,		,,		TON				TALBO	T	
	Funeral				Age (In yrs. la	st birthday)	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				8. Date of Birth (Month, Day,	Year)	9. Birthplace (Star Country)		or Foreign
	Director		292-18-5895	1101 M 2 F	97	Yrs.		50,0			DEC 21,			INOIS	
	and #		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	·-		1	0d. Inside (City Limits
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	th the	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen	of What Cour	ntry?	
	s 23e	ral	501 DUTCHMANS I		II C	21601						14.0	USA 14. Race - American Indian,		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exer, it are must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	es? □ No	If Yes, specify Cuban, Mexican, Puerto I			ecity Yes of No- Rican, etc.)	Rican, etc.) Black, Whi					
21215-0036	tural sul Ex	ed b	15. Decedent's		es.	16a. Dece	dent's Usua	I Occupa	ation		1	6b. Kind of	Business/Inc		
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nd	be file	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mail								ame)				
Maryland	should ind Men s marke umatic	ဥ	MELVIN LEE ATW 19a. Informant's Name/Relationship			19h Mailir	na Address	(Street a			CARPENTE al Route Number,		vn State Zin	Code)	
Z B	and 2 sealth an n 27 ls i		CORWIN L. ATWOO								SILVER S				
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altimore,	2 2 6 2		1 ☐ Burial 2 X Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		ate !		•			CTR	6/15/200	6 STE	VENSVI	LLE,	MD
Balti	permit. Pag Department Important: any injury once.	1 :	21. Signature of Funeral Service Lie	Shown	C.F.S.F.	22 F	2. Name an	d Addres	s of Facilit	y NBEI	N & NEWNA EASTON,	am Fu	NERAL		
	rnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or or control of the	a	r as a consequent	ence of):	who who who al a	a of dying	7		or respiratory arre	st,		Approxima Interval Be Onser and	ween Death Death
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Division of Vital Records,	The la ate has page 2	Completed	Degenensu	of fine	- ans	eup	-37) 11	yps		24a. Was an autopsy perform		 b. Were auto prior to condeath? 1 Yes 	mpletion of	; available cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			-	Othe			h (Check only one				
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2	2+1VA		30. Name and address of person w			/		T.AN	E 123.0	eron.	MD 2160	11			
	Sta	ate	31. Date filed (Month, Day, Year)	1 300	gistrar's Signat							-			

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	ryland			nt of Hea <i>te of De</i>		Mental Hy	giene Reg. No.	1005	20394		
	- 4		Decedent's Name (First, Middle,	Last)				·		2. Date of De	aath Day	Year	3. Time of Death		
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н	Funeral Director		224-56-8480	1□M 2⊠F 6.		Yrs.	Months		Hours Min.	(Month, Da	y, Year)	941 VIR	place (State or Foreign untry) GINIA		
	41		Usual Residence of Decedent			- :									
	arylar ehow	_	10a. State 10b. County			, Town or Lo							10d. Inside City Limits 1X□Yes 2□No		
	the M	ecto	MD PRINCE 10e. Street and Number	GEORGE'S	TI	EMPLE_		S ip Code			10a. Citi	zen of What Co			
	ath with the Marylan 23s or 28s-f show ust be notified at	흐	3354 HUNTLEY SQL	IARE DRIVE #	В2		, , , ,	20748				S.A.	,		
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			pecify Yes or No		14. Race - Amer Black, White			
036	within 72 hours after death with the Maryland ene.	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ื Divorced	d 1 Yes 2 No If Yes, Give Year or Dates:	0		1 ☐ Yes		мехісап, Риеп Specify:	o nicali, etc.)		BLACK			
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Maryland	iges t end 2 should be nt of Health and Menta if item 27 is marked or other traumatic ex	ဍ	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Addres	ss (Street and	Number or Ru	ural Route Numb	er, City o	r Town, State, Z	ip Code)		
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J.	of Hee		20a. Method of Disposition	CD	20b. Pl	ace of Dispo	sition (Nation)	ame of other place)		Date	20c. Lo	cation - City or	Town, State		
altimore,	Pages nent of ant: If its ary or o		1 ⊠Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		CHI	URCH C	EMET	ERY	6/17	7/2006			VIRGINIA		
Balt	permit. Pag Department Important: I eny injury o														
п		П	23a. Part1. Enter the disease, or o shock, or heart failure. List o	nty one cause on each line	A								Approximate Interval Between		
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	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ience of):									
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Box	or Attending Physician: The law requires that the deat" certifuler death. Director: After this certificate hes been signed by the attending in by the tuneral director, page 2 should be detached to: use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					1	23d. Date of deli Month	very Day Year			
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<u>Б</u>	res that the de signed by the a I be detached f	F.	Part II. Other significant condition	s contributing to death bu	it not resu	ulting in the u	nderlying	cause given i	in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?		
ds,	uires signe Id be	d by								10	Yes 2	□No 3□Pro	obabiy 4 ⊠Unknown		
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0	ding Ph h. After thi funeral		27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of Injun (Month, Day		28b. Time o Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred			
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Division of Vital Records,		Certification:	4 Homicide determin				reet, facto	ory, office		City or To			ral Route Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		Physician: To the best of xaminer: On the basis of and manner sta	examinat										
	To the To the Comp	Me	29b. Signature and title of certifier	1			2	9c. License n				e signed (Monti			
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2	(12)		30. Name and address of person v	luster 30	201	thico:	tal	Driv	e ch	7927 everly	N	m /s	vd.		
95	Sta		31. Date filed (Month, Day, Year) JUN 1 4 200	32. Registra	r's Signat	túte .	20		/	01					
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			For State Registrar	State of Maryland	/ Department of H			ene. UUb	20395
	Physici	an	1. Decedent's Name (First, Middle, Last)				June 5,	2006 Year	3. Time of Death
L	/Medic	_	Mattie A.	Banks			June 5,		2:40 AM
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or	Location of Death		4c. County of Death	
	F		Crescent Citie 5. Social Security Number 6. Sex		st birthday) If Under 1 Year	Riverdale If Under 24 Hrs.		Prince 9. Birthp	e George's
	Funeral Director			M 2K□F 100	Yrs. Months Days	Hours Min.	8. Date of Birth Jamonth, 1979, Y	1906 194	inia
	D		Usual Residence of Decedent 10a, State 10b, County	100 City	Town or Location				Od Inside City Library
	shov	,	10a. State 10b. County Maryland Prince 0		Riverdale			1	0d. Inside City Limits 1 X Yes 2 □ No
	28a-1	Funeral Director	10e. Street and Number	orge o	10f. Zip Code		100	. Citizen of What Cour	ntry?
	3a or	ā	4409 East West Hig	hway	20737			nited State	
	death ms 2	nera		I2. Was Decedent Ever in U.S Armed Forces?		spanic Origin? (Spe		14. Race - Americ	can Indian,
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Exemitier intel be mailled at	þ	1 ☐ Never Married 2 ☐ Married 3 🚰 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No	Specify:	nicari, etc.,	Specify: B1	lack
5-0	be filed within 72 ho tal Hygiene. d other than "natur event, Inc May Call	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Decedent's Usual Occupa (Give kind of work done d	uring most of working	ng 16	b. Kind of Business/Ind	dustry
121	within lene. than the Ma	ф	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	life. DO NOT use retired)			n .	
d 2	filed within Hygiene. other than		17. Father's Name (First, Middle, Last)		Resident	Manager 18. Mother's Name	(First, Middle, Ma	Priva	re
an	should be to and Mental I s marked of umatic eve	To Be	James Mallory			Mary Mu	rray		
Maryland	s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other t other traumatic event, III	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailing Address (Street a				/
	B # 2 T		Martha A.B. Thomas		3122 Gracefiel			ing, MD 20)904
ore	Pages 1 and 2 nent of Health s ant: if item 27 is ury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	CO	ace of Disposition (Name of metery, crematory or other place	p)	ate 20	c. Location - City or To	own, State
Baltimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify)	Ft.	Lincoln Cemete	ry June 1	12, 2006	Brentwood,	Maryland
Bal	permit. Pages 1 al Department of Hea Important: if Item any injury or othe once.		21. Signature of Juneral Service Licens					eral Home, ington, DC	
(5)			23a. Part Enter the disease, or compli	cations that caused the death.					Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Finaf	e cause on each line.					Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequent	tensive Cardio	vascular	Disease		
186	Examiner		Conventially that appelitions						
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	onte of,				
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687	ficate I physics the t	edical			2 %				
Вох	death certificate be executed e attending physicien end of for use as the burial-transit	Physician/Me	fF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan				23d. Date of delive	ery
	o death	sicia	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnant at time of dea				Month	Day Year
P.0	The law requires that the de ate has been signed by the a page 2 should be detached	Phy	9 Unknown		Wind the second of the second		00- 5:4		
	ires tha signed I be det	by	Part fl. Other significent conditions cor Advanced	dementia, Coli		n in Part I.		cco use contribute to the	**
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ior	Attending redeath. sctor: After by the fune	atlo	1 Natural 5 Pending investigation	(month, 50) 100/		es 2□No			
Division	ii or Attanca after death Diractor: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
Ω	To the Hospital or A within 24 hours after To the Funeral Dirac Completely filled in by		00 0 W 17 0 W	delete Technologie	dada- da da da da da da da da da da da da da				
	To the Hospital within 24 hours a To the Funeral dompletely filled	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	ner: On the basis of examination and manner stated.	rledge, death occurred at the tim on and/or investigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as si and place, and due to	tated. the cause(s)
	o the	Me	29b. Signature and title of certifier	3	29c. License	number	29d	. Date signed (Month,	Day, Year)
	(1)		· IVX	No-		D48213		June 9,	2006
•	Olp		30. Name and address of person who co					-	
	, ac		Neelam Asha		- 74th Ave., I	_andover	Hills, MI	20784	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signati	11 0				
DH	MH 17 Rev 1/2		4 2006	en & L					
			JUN 1 4 2006	7	ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene CUSYD For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JUNE 08'. 2006 CHESTER L. BOOKER 7:05A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CLINTON NURSING HOME & REHAB CLINTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex XX M 2□ F **Funeral** Days Months 95 Yrs. 24, 224 16 2815 NOV. 1910 VIRGÍNIA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Examiner must be notified at 1XXYes 2 □ No Director PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20735 6401 ELM WAY UNITED STATES iteme 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes XX No If Yes, Give 1 Never Married 2 Married ò 1 ☐ Yes XX No BLACK þ Specify: Specify: If Yes, Give Year or Dates: ₩Widowed 4 Divorced neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nont, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 6TH TRUCK DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental item 27 te marked o ROBERT BOOKER JULIA BURTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS GRIFFIN / DAUGHTER CLINTON, MD 20735 6401 ELM WAY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Depertment of H Important: If ite eny injury or ot once. ≥ Burial 2 □ Cremation 3 □ Removal from State FIRST MT. OLIVE BAPT. 06/14/2006 NEWTOWN, VA 4 Donation 5 Other (Specify) 21. Signa MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. 23a. Part1. Ei shock, o Approximate Interval Between Onset and Death Immediate Carse (Final disease or condition 17Heimers Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) it any leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed buriai-tran and Due to (or as a consequence of) ettending physicien Physician/Medical as the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Dav 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 200 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? (es 24No 1 ☐ Yes 2 No or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2XNo Other: 4XX Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35206 anne 7

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11201 Livingston Road For washington

31. Date filed (Month, Day, Year) JUN 1 3 2006

William

		1 - For State Registrar	State of Marylan		artment o rtificate d		R	eg. No.	05 2039
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last, A. Facility Name (If not institution, give		lat'	Be 4b. City, Tow	n, or Location of Dec	2. Date of Dea Month		Year 3. Time of Death Year 6.37 AM Death
Funeral Director		5. Social Security Number 6. Sec. 237 50 9352 10 Usual Residence of Decedent	7. Age (In yrs.	last birthday) 73 Yrs.	If Under 1 Ye Months Da			Year)	9. Birthplace (State or Foreign Country) NORTH CAROLIN
ne Maryland 8s-f show billing st	ctor	10a. State 10b. County MD CECIL		ty, Town or Lo	cation				10d. Inside City Limits XX Yes 2 □ No
eath with the	Funeral Director	10e. Street and Number 224 THOMAS JEFFERS 11. Marital Status	SON TERRACE 12. Was Decedent Ever in U	S 13 1	10f. Zip Cod	21921		UNITED	•
ours after d rrai, or iten		1 Never Married 2 Married 3 Widowed X Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify C		(Specify Yes or No- erto Rican, etc.)		White, etc. BLACK
Destrictions, Interpretation 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-1 show any nivry or other traumatic event, the Medical Examiner must be notified at angle.	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12TH	cation e completed) College (1-4or 5+)	16a. Deced (Give life. I		cupation ine during most of w tired)	rorking	16b. Kind of Busi	•
INGL PIGILO d 2 should be file th and Mental Hy 77 is marked oth traumatic svent	To Be (17. Father's Name (First, Middle, Last) JOHN WHITLEY		17.2		MELVII	ame (First, Middle, I	,	
of C, Ivians 1 and 2 st and 2 st of Health and Itsm 27 is no rother traun		19a. Informant's Name/Relationship (Ty EVELYN R. BENTON-S 20a. Method of Disposition XX Burial 2 Cremation 3 CF	SINKLER/DAUGHT	TER 2	-	MAS JEFFE	RSON TER. Date	ELKTON,	
permit. Pages 1 ar Department of Hea Important: If item any njury or oths		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	RES	SURRECT	TION CEN	METERY 06,	L HOME OF	CLINTO	D. INC.
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deather cause on each line.	h. Do not ente			D SUITLANI ac or respiratory arre		Approximate Interval Between Onset and Death) WOPK
ficate be executed by physicien and miles the burial-transit	edical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 1 1 1000	PIC uence of):					1 400
The law requires that the death certifical that has been signed by the attending progge 2 should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3	Ectopic pregna			23d. Date of Month	
en signed by	۾	Part II. Other significant conditions cor	Inbuling to death but not rest	ulting in the ur	nderlying cause	given in Part I.			ute to the cause of death?
The language 2	Completed						24a. Was ar autops perforn 1 🗆 Yes 2	ned? pric	ore autopsy findings available or to completion of cause of ath? Yes 2□ No
sician: Tr certificate irector, pag	o Be	25. Was case referred to medical examiner?	ospital:	FD/O to the		Oah a-	eath Check only one		
Attending Physician: The rideath. sector: After this certificate his by the funeral director, page	ation; To	27. Manner of Death 1 \[\int \text{Natural} 5 \[\text{Pending} \text{investigation} \]	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. lr	1 Nursing injury at Vork? ☐ Yes 2 ☐ No	Home 5 Reside		
To the Hospital or Attenwithin 24 hours effer deall fo the Funeral Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	v)			City or Town	, State)	or Rural Route Number,
To the Hospital within 24 hours e To the Funersi E completely filled	edicai	29a. Certifier fi Certifying Phys (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in m	e time, date and place y opinion, death occ	e, and due to the ca curred at the time, da	iuse(s) and mann ate and place, and	er as stated. d due to the cause(s)
Tot som	Σ	29b. Signature and title of certifier	. Caen	un	29c. Lice	9 59 24	0 -	9d. Date signed (i	Month, Day, Year)
-(2)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)	i Names V	NARY LANG	1 7/25	£7
St: Regist		31. Date filed (Month, Day, Year) ILIN 1 3 2006	32. Registrar's Signa	ture		11-101-11	7 117.01		

Please Type or Print in Black Indelible Ink

Aretha Beckman State of Maryland / Department of Health and Mental Hygiene UUS 20398 1- For State Certificate of Death Rea No Registrar 2. Date of Death Decedent's Name (First Middle Last) 3. Time of Death PŘysician/ Month Day June 4, 2006 1519 hrs Medical Examiner Arether F. Beckham 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign SOUT) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Foreign Director 247-46-7873 81 03/24/1925 CouCarolina 1 M 2 XF Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location Yes 2 No 28a-f show DCWashington death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 229 - 43rd Road, NE 20019 United States 23a Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, t be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Married 2 X No Yes 4 X Divorced Yes 2 X No specify Black Give Yea Specify Widowed 'natural', þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) d 2 should be filed within 72 ho lith and Mental Hygiene n 27 is marked other than "na numatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 12th Housekeeping Private 17 Father's Name (First Middle Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Hollis Fernanders <u>Luvenina Jones</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Pages 1 and 2 shent of Health an lant: If item 27 or other trauma Wash DC 200 20c. Location - City or Town, State NE #202 Reginald Beckham, Sr./Son 43rd Road. 20b. Place of Disposition (Name of cemetery, crematory or other place) artment or apportant: If? 1 X Burial 2 Cremation 3 Removal from State 6/10/2006 Mt. Olivet Cemetery Wash., DC Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses 4001 Benning Rd., NE Wash., DC 20019 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** List only one cause on each line /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED item#1,perME,G857,7/15/06 TI Physician/Medical physician the burial -UNPENDED Box 68760, 23c. If yes, outcome of pregnancy IE FEMALE 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death Day attending past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed' page ✓ Yes 2 1 🗸 Yes 2 No. 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 2 No 1 🗸 Yes ٩ 28a. Date of Injury (Month, Day,Year 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 V Natural 5 Pending Yes 2 No after death. Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 2 To the 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registra

			1 - For State Registrar	State o	f Marylan	-	artmen rtificat			and Me	ental Hy	giene Reg. No	7111	15	20399
			Decedent's Name (First, Middle	, Last)							2. Date of De	nath .			3. Time of Death
н	Physici /Medic		James Edward	Bowldi	ng						June	9,	2006	rear .	2:00p M
	Examin		4a. Facility Name (If not institution	, give street and nui	mber)		4b. City,	Town, or	Location o	of Death		- 1	. County of	Death	<u> </u>
			The Loving Ho	me Nursin	ng Home		Нуа	attsv	7ille]	Prince	e Ge	orge
	Funeral Director	-	5. Social Security Number 579–10–5871	6. Sex 1 M 2 ☐ F	7. Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bi (Month, Da Jan. 3	rth ay, Year,	010	9. Birthp Coun D	lace (State or Foreign
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	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wh	at Coun	try?
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	e e e e e e e e e e e e e e e e e e e	Funerai	11. Marital Status	Armed Fo	edent Ever in U. prces?	S. 13. \	Was Deced	dent of Hi	spanic Orig	gin? (Spec	ify Yes or No ican, etc.)	0-	14. Race -	Americ White,	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any fulury or other traumatic event, the Macical Examinat must be notified at once.	ToE	John S. Bowldi	ng					Mary	y Ma	ck				
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Baltimore,	it. Pa		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Qua	ntico						Tria	ing Le	, Vi	rginia
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г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death ach line.	n. Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):		-							
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<u>α</u>	that til ed by detac	/ Ph	Part II. Other significant conditio	ns contributing to de	eath but not resu	ilting in the ur	derlying c	ause give	n in Part I.		23e. Did t	obacco i	ıse contribi	ute to the	e cause of death?
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Ö	w requir s been si should I	jete									24a. Was	an	24b We	re auton	sy findings available
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ita		Bec	25. Was case referred to medical						26. Place	of Death (1 Yes	2 No	1	Yes :	2 NO
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Division of Vital Records,	or Attendater death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At hor ng, etc. (Specify	me, farm, stre	et, factory	, office		28	f. Location (. City or Tox	Street an wn, State	d Number (or Rural	Route Number,
	Hospitai 24 hours 8 Funerel I fely filled		29a. Certifier 1√ Certifying	g Physician: To the	hest of my know	vledne death	occurred :	at the time	n date and	t place, on	d due to the	22.12.2/2/			
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)	X			MDO	00458	381			Jun	e 14,	200	06
1	b) 1/4		30. Name and address of person v		e of death (Item	23a) (Type, I	Print)	Inno	Mori	lhom-	ма	207	77.		
7			Glen Jacobs, M.	do D	Mercant			pher	. rati	TDOLO	, rid.	207	/4		
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			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of artificate o		_	giene,	301.00
	Dis1.1		1. Decedent's Name (First, Middle, L	ast)				2. Date of De.	ath _	3. Time of Death
	Physici /Medio		Peggy Marie	Brown				June	10, 2006 Year	9:30am M
	Examir		4a. Facility Name (If not institution, g		er)	4b. City, Town	n, or Location of I	Death	4c. County of Death	
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	Funeral Director		5. Social Security Number 6. 579 28 9063 Usual Residence of Decedent	Sex 7. 1 □ M 2 ਊ F	Age (In yrs. last birthday 81 Yrs.	Months Day		Min. 8. Date of Birt (Month, Da	y, Year) Cou	place (State or Foreign intry) nington, DC
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	or 28g	Director	10e. Street and Number			10f. Zip Code	е		10g. Citizen of What Cou	ntry?
	th will	a	7620 Maple Aven	ue		2	0912		United Stat	æs
	r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin Juban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White	
3	hours after turel', or Ite	by Ft	1 Never Married 2 Married	If Yes, Give	∑No	1 ☐ Yes 2 1 N			Specify: Bla	
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Ē	ant,	Be C	17. Father's Name (First, Middle, La.	st)				Name (First, Middle,		
/lan	ould be Mental Marked c	ToE	unknown				Gert	rude Johns	son	
Mary	2 should and Men is marke sumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Number o	or Rural Route Numbe	r, City or Town, State, Zip	o Code)
≥ `	s 1 and if Health item 27 other tr		Rochelle H. Her	rbert-Daud		Glassmano	r Drive, C	Doon HILL, MC	20745	
HOL	ages 1 int of H t: If iten y or oth		20a. Method of Disposition Mathematical 2 □ Cremation 3	Removal from Sta	(()	matory or other p	olace)	Date	20c. Location - City or To	
	0 4 5		* 4 ☐ Donation 5 ☐ Other (Spec		Ft. Lin			5/17/2006	Bladensburg	, Maryland
galti	permit. I Departm Importal any inju		21. Signature of Funeral Service Lice	ensee		2. Name and Add			es Funeral Hom	е
		84 1	23a. Part1. Enter the disease, or co	mplications that cause				E Washington		Approximate
			shock, or heart failure. List oni Immediate Cause (Final	y one cause on each	line.	to the mode of o	iying, suon as ca	rdiac or respiratory an	iest,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. 56.69	as a consequence of):					
	Examiner			HVP		CEPHA	HOPAT	THY		
	_	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of).) []	1111		
	cuted nd ransii	Examiner	that initiated events	· PRE	VIOUS A	ESP1	RATOP	W FA	ILURE	
00,	e exe		resulting in death) Last	Due to (or	as a consequence of):		. 0	7 (00)	0	
0	certificate be executed Iding physician and Ise as the burial-transit	dical		a. Con	LONAILY	AIL	TERY	8) SETIS	P.	
o O O	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	an of pregnancy				-20	
8	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of delive Month	ery Day Year
j	y the	Physiclan/Me	1 □ Yes 2 X No 9 □ Unknown	9☐ Unknown		_ Other (specily)				
Γ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause	given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
records,	quire an sig uld b	pa pa	(1) PROBABLE 15	10 HCHOG	thic car	CHOMP		1 🗆 Y	es 2⊡No 3⊕ Prob	oably 4 🗆 Unknown
္ဌ	aw re	plet	2) RENAL FR	HLDILE	, 3DIA	BETES	MELLIT	1 274. 1143	ın 24b. Were auto	psy findings available
Ĕ	The I	Completed by	9 PILEVIOUS 5-	TROKE	5 5 SE12	URE DI	SONDE	autops perfor	med? death?	mpletion of cause of 2☑ No
ם א	striffica ctor, I	Bec	25. Was case referred to medical examiner?		700		26. Place of	Death (Check only or		EQ. NO
5	hysic his co	٥	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		IL 3 DOA	Other: 4X Nursin	ng Home 5 🗆 Resid	ence 6 □Other (Specif	y)
	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of ir (Month, L	pjury 28b. Time o Day Year) Injury	W	/ork?	28d. Describe h	ow injury occurred	
NISION	ttend death stor: /	icat	2 Accident investigate 3 Suicide 6 Could not	be one Diese of I	nium. At home form at		∐Yes 2∐No	ORA Laurian (O		
2	lor A after Direction by	Certification:	4 Homicide determine	building,	njury - At home, farm, st etc. (Specify)	reet, factory, offic	е	City or Town	treet and Number or Rura n, State)	I Houte Number,
-	To the Hospital or Attending Physician: The law requires that the death within 24 burus after death. within 24 burus after death. completely filled in by the funeral director, page 2 should be detached for to completely filled in by the funeral director, page 2 should be detached for the funeral director.	edical C	29a. Certifier 1 Certifying P	hysicien: To the be	st of my knowledge, deat	h occurred at the	time, date and p	lace, and due to the c	ause(s) and manner as state and place, and due to	ated.
	the hin 24 the F	Med	one) 29b. Signature and title of certifies	and manner	stated.		nse number			
	7 × 0		1 Marmina	A. IVOV	man M	Da	4593		9d. Date signed (Month,	0
	(b)		30. Name and address of person who	completedvause	Neath (Item 23a) /Temo	Print) Q O	31 60	I EDU TO	29400	
			MOHAMMED A	11 [1211]	1 Ata Millo	() H	ATT	SVILLE	MD 20	782.
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signature	de!				

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Natificate of Death		giene 006	20401
12	Physici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Yea	3. Time of Death
	/Medic		Maurice Henry Borders		de	12 04	A 11
1.00	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
		d of	Doctors Community Hospital	Lanham If Under 1 Year If Under 24 Hrs.	0.000		George's
70 - 24	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Vrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day 8/22/35	Year) Wa	lirthplace (State or Foreign Country) sh.,D.C.
	land ow		10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary if sh	tor	Md. P.G. Lanham	Ω			Y⊟Yes 2 No
	r 28s	irec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What	Country?
	23a c	aiD	9857 Good Luck Road # 11	20706		U.S.A.	
5-0036	filed within 72 hours after death with the Maryland Hygiens. Ither than "natural; or Items 23e or 28e-f show ent, Itte Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2% TNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. Black
2	72 ho	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work	ina	16b. Kind of Busines	ss/Industry
2	ithin 18.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		L	
2	filed with Hygiene. other than	Cor	12th	Sales Clerk		Liquor St	ore
Maryland 2121	bd ba	To Be	17. Father's Name (First, Middle, Last) Thomas M. Borders, Sr.	18. Mother's Nam Euph:	e (First, Middle, I remia Ke		
	nd 2 sulth ar 27 is r trau		Edward Bordors / Brother	ing Address (Street and Number or Run) Nash St., N.E., Was			
e e			20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐ Removal from State	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Ĕ	Pages ment of ant: If it ury or o		TE Build 220 Cremation 5 Enternoval noin State	ake Crematory, Inc.	6/16/0	6 Beltsv	ille.Md.
Baltimore,	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service Licensee	² Name and Address of Facility H. S. Washington & 1 1925 Burroughs Ave	Sons Co.	Inc.	D.C. 20019
		Ų.	23a, Part1, Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate
	Pnysician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Respiratory Sepsis	Fa	lvve	Interval Between Onset and Death
	Examiner	ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jegs, s			
	xecuted and II-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
9/90	certificate be executed iding physician and ise as the burial-transit	icai	d				
O. Box 6	ath certific attending p for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
ds, P	w requires that the de been signed by the a should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tot		to the cause of death? Probably 4 Unknown
Ö		lete	Mal Outs tim)	24a. Was a	n 24h Were	autopsy findings available
Vital Records,	The ate h page	Completed	AICOWI ADUSC		autops	v prior to	completion of cause of
	Physician: this certific ral director,	Ве	25. Was case referred to medical examiner?	26. Place of Death		-	
0	Phy this ral d	1: To	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Nation 2 ☐ ER/Outpatier 27. Manner of De th	A Nursing Ho		ence 6 Other (Sp	ecify)
o	tending I death. tor: After the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c, Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 0030/100 //0	w injury occurred	
DIVISION	or Attending after death. Director: After in by the fune	ertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
	s Hospital or Atten 24 hours after deat 9 Funeral Director: etely filled in by the	edical Ce	29a. Certifier (Check only one) Medical Examiner. On the basis of examination and/or in an examination and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the ca	use(s) and manner a	is stated. le to the cause(s)
	To the Hosp within 24 ho To the Fune completely fi	Med	one) and manner stated. 29b. Signature and title of position	29c. License number		9d. Date signed (Mor	
	F 3 4 8		Me		2	L I n	Cay, real)
16	2		20 Name and address of automatic and a state of the state	MDD 60611		0117	12006
-	リー		30. Name and address of person who completed cause of death (Item 23a) (Type,	571/66 - 50/75 3	, / 1	1000	1
1/8	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Print) STKEET SUITE 3	31 4	URZL, RY	20101
1	Registr		31. Date filed (Month, Day, Year) JUN 1 5 2006 32. Registrar's Signature	W .			

Borders, maurice

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2006 **Physician** Month Belinda Yvette Byrd-Douglas June 13, 9:33 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 957 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 48 Director 579-80-1630 Yrs November 27. Washington, D.C Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Medical Examinal must be notified at ¹X Yes 2 □ No Directo District of Columbia Washington the 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 730 Oneida Place, N. W. 20011 2 should be filed within 72 hours after death is and Mental Hygiene.
Is marked other than "natural", or items 224 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: **Black** 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) D.C. Dept. of Health Elementary/Secondary (0-12) College (1-4or 5+) 3 years Human Services Peer Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be .. Pages 1 and 2 should be timent of Health and Menta tant: If item 27 le marked ljury or other traumatic en **William** Byrd ဥ Eva Pearl Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 19a. Informant's Name/Relationship (Type, Print) 10708 Glenhaven Drive; Silver Spring, Maryland Eva Pearl Smith (Mother) June 15, 2006 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. Beltsville, Maryland 21 Signature of Puneral Servi 22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Central Nervous System Bleeding /Medical Due to (or as a consequence of). Examiner Metastatic Uterinesarcoma Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Pulmonary Embolism physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for L 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be 1 ☐ Yes 2 ☐ No Completed 3 Probably 4XXInknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No ٩ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after the Hospitai within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kshan D60826 June 13, 2006 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) Khawaja Garg, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 6 2006

			For State Registrar		Ce	rtificate of	Death		leg. No.	JUb	20400
	Physici	an	1. Decedent's Name (First, Middle, L	,				2. Date of Dea Month	pay I I	Year	3. Time of Death
П	/Medic		Minnie Lenza		attisaw			6		ďő	8:05 A M
	Examin	er	4a. Facility Name (If not institution, gr				or Location of Death		4c. County		
			8116 Gavin St		n yrs. last birthday		rrollton				eorges
	Funeral Director			1□M 2)©F 86	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 4/2/1	920	Go1	place (State or Foreign http) dsboro NC
	yland how		10a. State 10b. County	10	0c. City, Town or Le	ocation				1	0d. Inside City Limits
	e Ma	cto	MD. Prince	e Georges 1	New Car.	rollton					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	s 23a	rai	8116 Gavin St		1.110	20784			United		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23e or 28e-f show event, The Medical Evantral must be notified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Types 2 Types If Yes, Give Year or Dates:		was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 → No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		ce - Americ ck, White, fy: B1 a	
Ö	72 ho natur	Completed	15. Decedent's I (Specify only highest g	Education	16a. Dece	dent's Usual Occup	pation	ina	16b. Kind of B	lusiness/In	dustry
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2	e filed within al Hygiene. other than '	S	12th		Dome	estic			House		per
and E	be fi	Be	17. Father's Name (First, Middle, Las				18. Mother's Name Minnie	(First, Middle,	Maiden Sumar		
ž	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	ဥ	Romus Bu 19a. Informant's Name/Relationship	(Type Print)	10h Maili	na Address /Street	and Number or Rura	A Pouto Mumbo	City or Tour		nk.
<u>8</u>	d 2 s th an t7 is 1		John Lattisav				St., New				
	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			-	20c. Location		
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	- Meniovar noin State	Riverda		I	3/06	River	- 	MD
≣	# 튼튼증 .		21. Signatore of Fundal Solvice Lice			2. Name and Addre	-	3700 _			Street NE
ä	Depa fmpo eny is		P. Acarica	terran mo	1178	B.K. Hei	nry Fune	ral Ho			C.20002
į,	Physician /Medical		23a. Part 1. Exter the disease, or conshock, or heart failure. List online immediate Cause (Final disease or condition resulting in death)	mplications that caused the yone cause in each line. Congest: a. Due to (or as a co	ive Hea			or respiratory arr	est,		Approximate Interval Between Onset and Death 1 yr.
П	Examiner		and the second second	b. Atrial Fi	ibrillati	on					unk
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that printed events.	Due to (or as a co	onsequence of):						
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	n requires that the been signed by should be detact	by	Part II. Other significant conditions	contributing to death but n	not resulting in the u	inderlying cause giv	ven in Part I.		bacco use cont es 2 🗆 No		ne cause of death? ably 4 ⊠Unknown
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<u>i</u>	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Handini.		Out.	26. Place of Death	(Check only on	ie)		
of .	> 0 0	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	and the second second	IL 3L DOA	ner: 4 Nursing Ho				/)
Z	ting f	io	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wor	rk? Yes 2 ∐ No	28d. Describe h	ow injury occur	Tea	
Division of Vital	I or Attending after death. Director: After I in by the fune	Certification:	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be Ose Blees of Injuni	- At home, farm, st Specify)			28f. Location (Si City or Town		oer or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edicai C	29a. Certifier 1 X Certifying F (Check only one) 2 Medicel Exa	Physicien: To the best of maminer: On the basis of ex aminer: Aminer stated	amination and/or in	h occurred at the til	me, date and place, a opinion, death occurr	and due to the cased at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)
	0		11/8 86	165		MD/	7194		6/13/	1200	6
	141		30. Name and address of person who	o completed cause of death	h (Item 23a) (Type,	Print)	- /		/		
_	U			urtis, MD		ranklin S	Street N.E	. Washi	ngton,[).C.	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 5 200	2. Registrar's	Signature	R)					

			1 - For State Registrar	State of Maryland		epartment of He Certificate of D			iene	2006	20401
	Physici	an	Decedent's Name (First, Middle, Last)	John T. Be	aab			2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give st.		acıı	4b. City, Town, or	Location of Death	June	9 4c. Co	2006 ounty of Death	9:35a ^M
	Funeral Director		Buckingham's Choice 5. Social Security Number 720-10-6112 6. Sex	7. Age (In yrs. Ia M 2□F	st birtha Yrs	Adam	Stown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Frede 9. Birthpl Coun	rick ace (State or Foreign try) York
	and w.		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town o	r Location				10	Od. Inside City Limits
	Maryl	tor	Maryland Frederic	k Ada	nsto						1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show Li wat be mulling at	Directo	10e. Street and Number	Ada	посо	10f. Zip Code		1	0g. Citizen	n of What Coun	try?
	s 23s	ral	3134 Periwinkle Cou		1	217				ed State	
920	s 1 and 2 should be filed within 72 hours after death with the Maryla I Heath and Mental Hygiene it Ifom 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, Ite M. Alcal E.S., nitrett and be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWTT		13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	city Yes or No- Rican, etc.)		Race - America Black, White, e pecify:	
5	72 hou		15. Decedent's Educa (Specify only highest grade	ation	16a. De	ecedent's Usual Occupa	tion	100	16b. Kind	of Business/Ind	
7	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lit	e. DO NOT use retired)	Thing most of working			Nu	ıclear
א כ	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	4		Architect	18. Mother's Name			trialPo	wer
0	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M.	To B	John Beach				Margaret			,	
	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. M	ailing Address (Street ai	nd Number or Rura	Route Number	, City or To	own, State, Zip	Code)
ב ע	1 and Health em 27 ther to		Barbara J. Beach /	Wife 20b. Pla	3134	4 Periwinkl	e Court,			laryland	
2	ages ent of nt: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State cer	netery,	crematory or other place)			•	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licenses			ck Cremator 22. Name and Address Stauffer Fu	of Facility Ineral Hot	ne P. A			Maryland
			23a. Part1. Enter the disease, or combice shock, or heart failure. List only one	ations that caused the death.	Do not	1621 Opossi enter the mode of dying	umtown Pi , such as cardiac oi	ke, Fre	deric est,	k Maryl	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cingst Due to (or as a conseque	We	- Heart	- Fail	we			Interval Between Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions, b.	Due to (or as a conseque	ETi	55					
	nd nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	R (ENSION					
0/00	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conseque	ince of):						
00	ing phy		IF FEMALE:							. 1	
0.0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	 if yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown 	leath	3 □Ectopic pregnancy 5 □ Other (specify)			23d.	Date of deliver Month	y Day Year
ָר (CD)	uires that signed by Id be deta	by	Part II. Other significant conditions control	ibuting to death but not result	ing in th	e underlying cause giver	n in Part I.	23e. Did tob	_	_	e cause of death?
2	aw requir s been si 2 should	ompleted						24a. Was a		4b. Were autop	sy findings available
	The lav	Com	7 (10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to					autops perform		death?	pletion of cause of 2□ No
A II A	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	enit al-			26. Place of Death				
5	Phys	: To	1 Yes 2 No 27. Manner of Death		R/Outpa		Nursing Hom	e 5 Reside			
5	inding ath. r: Afte	atior	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Inju	y Work?	es 2 No		jury oo	201100	
	To the Hospital or Attending Physician: To the Hospital safter death. To the Funeral Director: After this certifica completely filled in by the funeral director; I	Certification;	3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm,	street, factory, office	2	Bf. Location (Sti City or Town		umber or Rural	Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, de n and/o	eath occurred at the time r investigation, in my opin	e, date and place, an nion, death occurre	nd due to the ca d at the time, da	use(s) and ite and plac	d manner as sta ce, and due to t	ted. he cause(s)
	Son With To	2	29b. Signature and title of gertified	re		29c. License	7313	29	Od. Date sig	gned (Month, D	ay, Year)
V)* ('		30. Name and address of person who com	pleted cause of death (Item 2	(Ty	De, Print)	WE B	ALTIN	ORE	MA	21201.
	Sta Registr		31. Date filed (Month, JUN 1 6 2	32. Redistrar's Signatu	J.	Spell	, , , ,				

			1 - State Registrar			ı Maryla		artment of H			Reg. No.	105	20405
	Physic /Medi		1. Decedent's Name		м.	Brecht				2. Date of De Month	Day	Year 2006	3. Time of Death
	Examir		4a. Facility Name (/					4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
					& NURSI				Y, MD. 2			OMICO	
	Funeral Director		5. Social Security N 095-18-10 Usual Residence of	082	3. Sex 1	7. Age (In yrs	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/6/19)	th ay, Year) 25	9. Birthp Count New	lace (State or Foreign try) York
	death with the Maryland me 23s or 28e-f ehow Finust te notified at	_	10a. State	10b. County		10c. C	City, Town or Lo	ocation				1	0d. Inside City Limits
	Be-f	cto	Maryland	Wicom	ico		Salis	bury					1 ☐ Yes 2X☐ No
	ih th	Dire	10e. Street and Nur					10f. Zip Code			10g. Citizen o	of What Coun	try?
_L	ath w	ā		Early Da	wn Court			2180			USA		
ech.	ē # #	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Marrie 4 □ Divorced	Armed Fo	2 ∑X No ve		Was Decedent of Hi f Yes, specify Cuba 1□Yes X □ No		pecify Yes or No o Rican, etc.)	Spec	lace - Americ lack, White, cify: Wh	
9 5	72 hc	etec	/Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Occupa	ation	kına	16b. Kind of	Business/Inc	lustry
13 rec	l within iene. r than	Completed	Elementary/Seco		College (1-4or 5+)		kind of work done of DO NOT use retired	i)	ung	Dome	stic	
	Hyg ethe	BeC	17. Father's Name	(First, Middle, La	est)				18. Mother's Nam	ne (First, Middle			
0) =	ld be fenta rked ricev	To B	Edward	Hoffman					Elizabet	th Welch	n		
OS &	shou and N me	-	19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or Tow	m, State, Zip	Code)
•	and 2 alth a		Cheryl L.	Peters	/daughte	r	282	78 Early	Dawn Cour	ct, Sali	isbury,	MD 21	801
OX &	of He of He ritan		20a. Method of Disp		☐Removal from	a	Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location		
Ralfimore C.	permit. Pag Department Important: I any injury o			5-Q Other (Spe	city)	ЬC	'amatarı	Name and Addres	0/		Long	Island	, NY
n n	89559		Yu	n to	Loh-			501 Snow	Hill Rd.	Salisk	oury, M	D 2180	sociation 4
	Pnysician		Immediate Cause ((Final	omplications that only one cause on a	aus d the dea	ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	n d	a. Due to	as a nee	quence of):	e a	new	Cos	ncey	1	1 lay=
	Examiner				Rt	a ko e		1	an o-	Ta		1	7.2
		ner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	nditions, nmediate	Due to	r as a conse	quence of):					7	err
	icate be executed physician and s the burial-transit	Examiner	that initiated events	5	c							1000	
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O. Box	Attanding Physicien: The law requires that the death certificate be executed refeath. etter: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ysician/N	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? □No		oirth 2 Fet nant at time of	al death 3	Ectopic pregnancy Other (specify)	<u>-</u>			Date of deliver Month	ry Day Year
۵	that the the sed by detail	/ Physi	Part II. Other signif	icant condition	s contributing to d	eath but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to the	e cause of death?
rds	requires tha been signed should be de	ed by								10,	Yes 2 No	3 ☐ Proba	ably 4 □Unknown
ပိ	law requas been 2 should	Completed								24a. Was		. Were autop	sy findings available
ă	The I	E								autor perfo	rmed?	death?	npletion of cause of
<u>e</u>	ilcien: Th certificate rector, pag	Bec	25. Was case refer	red to medical					26. Place of Deat			10103	20 140
>	Physicien: this certific al director.	ToE	examiner? 1 ☐ Yes 2 €	MG	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Othe				ther (Specify)
Division of Vital Records. P.O.	ding Ph h. After th funeral		27. Manner of Death 1 Matural	h 5 ∏Pending investiga		of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe			
isi	Attending to death	fica	2 Accident	6 Could no	be 28e. Place	of Injury - At h	nome, farm, str	eet, factory, office	2 2 2 140	28f. Location (5	Street and Num	nber or Rural	Route Number.
ij	itel or At ins after d ral Direct led in by	Certification:	4 🗌 Homicide		buildi	ng, etc. (Speci	ify)			City or Tov	vn, State)		
	To the Hospitel or Attand within 24 hours after desit To the Euneral Director completely filled in by the	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	aminer: On the b	best of my kn- asis of examina ner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as sta , and due to	ited. the cause(s)
	To t To t	Σ	29b. Signature and	title of certifier	11)			29c. License	number		29d. Date sign	ed (Month, D	Pay, Year)
	Qo.		100 11Ken 02 8547 0/15/78										
	000		30. Name and address							4	1		
7	12				1140			SALISBURY	Y, MD. 2	1804			
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		1 _ For	State of Maryland / Dep		Mental Hygier	nes non	2010
		Registrar		ertificate of Death	Reg. I	vo. 4000	4 U H U
Physic	ian	1. Decedent's Name (First, Middle, Las	. 7		2. Date of Death Month	Day Year 3.	Time of Death
/Med		DORIS JEAL	U BERRIAN		June 11		12:30 M
Exami	ner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	h 4	4c. County of Death	
		62/-LIBERT	-y 57	SAUSBURY		WICOMI	6.0
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birthday,	y If Under 1 Year If Under 2. Hrs Months Days Hours Min.	(Month, Day, Yea	9. Birthplace Country)	(State or Foreign
		Usual Residence of Decedent	65		11-22-	.42	Un
yland		10a. State 10b. County	10c. City, Town or L	ocation		10d, I	Inside City Limits
Mar B-f-el	ior	md Wico	mico SA	LISBURY		1	Yes 2□No
or 28	Director	10e. Street and Number		10f. Zip Code	10g. 0	Citizen of What Country?	
be filed within 72 hours after death with the Maryland nial Hyglene. Identition "netural", or items 23e or 28a-f ahow avent, tra Madical Examination manks indiffied at		627-LIBERT	-V ST.	21804		USA	
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - American Ir Black, White, etc.	ndian,
od within 72 hours affe giene. er then "neturel", or fl , tre Meulical Evenin	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 No	1 ☐ Yes 2 No Specify:		79.	2
hours	Completed by	3 ☐ Widowed 4 Divorced	Year or Dates:			DLIT	
n 72	lete	15. Decedent's Edi (Specify only highest grad	te completed) (Give	edent's Usual Occupation a kind of work done during most of wo. DO NOT use retired)		Kind of Business/Industr	
filed withi Hygiene. other than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	5000 D		SCHOOLE H	
filed Hygid other ent, tr		17. Father's Name (First, Middle, Last)	I NU	The state of the s	me (First, Middle, Maide		OSFILAL
should be nd Mental marked o	To Be	MANDIE	BERRIAN	Dopath	w whi	TOL	
S D E E	-	19a. Informant's Name/Relationship (T		ing Address (Street and Number or Ru	iral Route Number, City	or Town, State, Zip Cod	(e)
		WARLINDA WAR	D-DAUGHTER 62'	7- LIBEATY ST	SALISBI	1	1804
Dermit. Pages 1 an Department of Heal mportant: If item 2 iny injury or othar 2008.		20a. Method of Disposition	20b. Place of Dispo	osition (Name of imatory or other place)		Local n - City or Town,	State
Pages nent of ant: If its ary or o		1 Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,	nemoval from State		6/06 5	ALISBURY.	M/N
permit. Pag Department Important: any injury o		21. Signalure Funeral Service Licens		2. Name and Address of Facility		MITH FI	11 11
Dep Dep Imp		Tuscella	, knings 9	17W. ISABELLA	ST SALIS		1801
		23a Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not entered the cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	(App	roximate rval Between
Physician		Immediate Cause (Final disease or condition	Carcinona	of Parcincas		Ons	et and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1			years
Examiner		Sequentially list conditions.	b				
pe sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequence of):				
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c				
e be executed sician and burial-transit	calE						
w : w	de		J		***		
death certificat e attending phy d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery	
death a atte d for	cla	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month Day	Year
that the d ed by the detached	hys	9 Unknown	9□ Unknown				
requires that the een signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cau	use of death?
quire an sig uld b					1 ☐ Yes 2	2 No 3 Probably	4 Unknown
law requir as been si 2 should I	Completed				24a. Was an	24b. Were autopsy fi	ndings available
0 = 0	mo				autopsy performed? 1 ☐ Yes 2 🖼	prior to completi	ion of cause of
	a l	25. Was case referred to medical		26 Place of Dea	th (Check only one)	0 1 ☐ Yes 2 ☐ I	No
d S	To B	examiner? 1 ☐ Yes 2 12No	lospital:	0.1	ome 5 Residence	6 ∏Other (Specify)	
Attending Physician: r death. ector: After this certified by the funeral director; i		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. scribe how inju		
auth. or: Af	atlo	1 Accident 5 Pending investigation	(Marian, Bay Foar) Injury	M 1 Yes 2 No			
or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Rou	te Number,
rs aft rs aft al Di	Cer		(0,000)//		ony or rown, oral	(6)	
Hospital or A Hours after Funaral Dire etely filled in b	edical	(Check only 2 Medical Exami	sician: To the best of my knowledge, death	h occurred at the time, date and place	and due to the cause(s	s) and manner as stated.	20122(2)
To the Hospital or Attending Ph within 24 hours after death. To the Funaval Director: After thi completely filled in by the funeral	Med		and manner stated.				
To To		29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, 1	*
D.		17/00/		030690	50	ne /3 20	06
3			empleted cause of death (Item 23a) (Type,	Print)	2=	ne /3, 20	
101		145 E. Coroll 31. Date filed (Month, Day, Year)	57 57/.550rg	no, James	E. MA.	27 W M.	ρ.
Sta Regist	-	IIIN 1 5 200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 2000

			1 - For State Registrar	State of Maryla		rtificate of			JIENES U U No.	0 2040
*	Physic /Medi		1. Decedent's Name (First, Middle, La Hilda A. Breade					2. Date of Dea Month June	Day	3. Time of Death Year 1:10 PM
1	Exami		4a. Facility Name (If not institution, given Anne Arundel Median Records)				r Location of Death Annapolis		4c. County of	
4	Funeral Director		377-03-3330	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9/16/1), Year) 1917	9. Birthplace (State or Foreign Country) Washington, DC
	a-f ahow	tor	Usual Residence of Decedent 10a. State Maryland Anne Ar		City, Town or Lo		apolis			10d. Inside City Limits P Yes 2 ☐ No
4	23a or 28	Funeral Director	10e. Street and Number 19 Harness Creek	View Ct.		10f. Zip Code	21403	1	10g. Citizen of WI	hat Country? J.S.A.
036	The agos ranks and Mental Hygiene. ordant: If Itam 27 is marked other than "natural", or items 23a or 28a-f ahow njury or other traumatic avant, the Medical Examiner must be notified at a		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decedent of H if Yes, specify Cuba 1 Yes 2XXIII	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
21215-0036	ene. than "natur	Be Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			dent's Usual Occup kind of work done o DO NDT use retired Homemaker	ation during most of work d)	ing	16b. Kind of Bus	
aryland 2	ental Hygis kad other ic avant,	To Be Co	17. Father's Name (First, Middle, Last) Samuel Jerrell)			18. Mother's Name	e (First, Middle, I le Toomb	Maiden Sumame	
Š	lealth and Mental m 27 is marked of her traumatic av	-	19a. Informant's Name/Relationship (Judith Floyd/da		19b. Mailin 19 Ha	ng Address (Street o	and Number or Rura	al Route Number	r, City or Town, S apolis,	tate, Zip Code) MD 21403
Baltimore,	nent of Hearn nt: If itam iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content			sition (Name of natory or other place In Cremat				ity or Town, State
Balti	Department of Important: If any njury or once.		21. Signature of Funeral Service Licer	- Howard I	22	. Name and Addres	ss of Facility Joh	ın M. Ta	ylor Fur	neral Home
	hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause or each line. a. Due po(or as a conse	Der	Hemot	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Setween Onset and Death
\$2 2 2	xaminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Slizur Due to (or se a conse	o ac quence of): Tract	fivition Interior	tion			days
68760,	physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a conse	quence of):	home)			days
· Box	e attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	
Records, P.O	been signed be should be deta	þ	Part II. Other significant conditions of Demontra	ontributing to death but not re	sulting in the un	iderlying cause give	en in Part I.			ute to the cause of death?
I Records,	ate has ber page 2 sho	Completed						24a. Was ar autops perform	y prid ned? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 No
of Vital	certificate rector, pag	o Be (25. Was case referred to medical examiner?	Hospital:		2□ DOA Othe	26. Place of Death	Check only one	9	
	th. : After this funeral dir	-	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2		nce 6 Other winjury occurred	
DIVISION	Dir	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)			28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
UN Pospital or	n 24 hours on Funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and mann ite and place, and	er as stated. d due to the cause(s)
Tot	within 2. To the I	M	29b. Signature and title of certifier	in mo		29c. License	3 (/ /	29	6/12/	Month, Day, Year)
			017 17 . 0 17	completed cause of death (Ite	EDICAL	i pray	. ANN.	APOLIS	5,m0	21401
	Sta Registr		31. Date filed (Month, Day, Year)	000 32 Registrar's Sign	ature de	nde)				

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State of Maryland	/ Department of Health a	nd Mental Hygiene 🖰 🕕 🕕

20408 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year (41 **Physician** RALPH EUGENE BIDLE, SR. 3 2006 JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown 146 Southern Oak Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1⊠M 2□F 87 Yrs. Dec.19, 1918 216-12-4926 Mary land Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County Item 27 is marked other then "neturel", or Items 23e or 28s-f show other treumstic event, the Modical Examinations the notified at 1 ☐ Yes 2√ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 146 Southern Oak Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: ↓ 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced WWIT 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Importent: if Item 27 is marked other then "ne any injury or other treumatic event, Ite Modified. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Trucking 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter Samuel Bidle, Sr. Vergie Gaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Louise Bidle/wife 146 Southern Oak Drive, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Zion Lutheran Cemt. 6-26-2006 Middletown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lightsee 504 Main Street 22 Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 alles upla 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rectal Concer (Melzsphie) **Physician** MUNTS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a division upon of Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? ŏ Month Dav Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes certificete 1 Yes 2 No Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Tes 2 No 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 5 Pending 1 Natural М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6.25.00 0 41667 Nelou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Congus Michael O McCorneck 31. Date filed (Month. Day, Year) State marke JUN 2 9 2006 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

physician and the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the should be detached

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

3. Time of Death Month **Physician** 9 0238 AM Boy 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 10 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours UNKNOWN Yrs. Director May 18 Maryland 2006 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MoL Baltimore Baltimore 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 2533 BarnES/EU Place 21244 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 7 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permil. Pages 1 and 2 should be filed within 72 hours after Depurment of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or iter any njury or other traumatic event, the Medical Examinat once. 1 Never Married 2 Married 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nonE none none nonE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Natasha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sume as 108 above Natasha Bryce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Method of Disposition

| Burial 2 Cremation 3 Removal from State
| Donation 5 Other (Specify) Hospital
| Signature | Funer LS west Licensee 13 post 06 Sinai HOSPITAL 22. Name and Address of Facility JINAI HOSPITALOF 21. Signature of Funeral Syrvick Licensee 2401 W. Belvenere Ave, BAL 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NECrotizina 12 hours /Medical Examiner EXTFEME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO061593 JUNE 9,2006 and address of person who completed cause of death (Item 23a) (Type, Print) ZYUI W. BEIVEDETE AVE. Kanter, Sinub Baltimore, Md 21215 32. Redistrar's Signature 9 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

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Registrar

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			1 - For State Registrar	State of M	aryland / Do	epartme C <i>ertifica</i>				lental Hy	/giene	(000	20411
			Decedent's Name (First, Middle, Last)							2. Date of D	eath	V	3. Time of Death
	Physic /Medi		IRENE BUCK	HAM						りっか E	Bay	2 00 L	11:20 AM
/	Examir		4a. Facility Name (If not institution, give JoHN SHOPKINS BY					r Location		>		ounty of Death	
Ī	Funeral Director		5. Social Security Number 6. Sec		ge (In yrs. last birth 68 Yı	Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Sept.	irth ay 7193	9. Birth Ball	place (State or Foreign of MD MD
	e Maryland	Director	Usual Residence of Decedent 10a. State 10b. County MD None		10c. City, Town	ore							10d. Inside City Limits 12∭ Yes 2 ☐ No
	23s or 2	al Dire	10e. Street and Number 2122 Cameron Driv	e Apt.#1	A		ip Code 1222				10g. Citize Unit		
036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23s or 28a-f show minjouryor other traumatic event, if a Medical Examinating the notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	•	13. Was Dec If Yes, sp	ecify Cuba	lispanic Or an, Mexica Specify:	n, Puerto	ecify Yes or N Rican, etc.)		4. Race - Ameri Black, White Specify: Whi	etc.
ر د	72 h	etec	15. Decedent's Edu (Specify only highest grad		16a. C	Decedent's Us Give kind of w life. DO NOT	ual Occup	ation during mos	st of worki	ing	16b. Kind	d of Business/Ir	ndustry
121	within ene. than "	mpl	Elementary/Secondary (0-12)	f year	Sec Sec	iii. DO NOT Cretary		1)		•	Key	Point N	Medical
Baltimore, Maryland 21215-0036	ild be filed lental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) John Bolton			ame (First, Middle, Maiden Surname) et Wood							
Mary	nd 2 shou alth and M 27 is mai	-	19a. Informant's Name/Relationship (T) Lyle Burnham (pe, Print) Son)	19b. J 14	Mailing Address 23 Sea	s (Street brool	and Numb K Ave	er or Rura • Cai	ry, NO1	rth Ca	Town State, Zi arolina	27511
Imore,	Pages 1 e nent of He- ant: if item uryor othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of D cemetery, Howard	Disposition (Na crematory or Unive	ame of other place rsit	y Sch	. 6,	Date /12/06		ation - City or T shingtor	
Balt	permit. Depertrimports any inju		21. Signature of Funeral Service Licent	•		22. Name Austi 3821	nd Addre n Roy 14th	ss of Facili yster Stre	Fune	eral Ho Washi	ome ington	n, DC 20	0011
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	Examiner	Examiner	Sequentially list conditions, any, leading to inmodals cause. Enter Underlying Cause, Disease or injury that initiated events	END	a consequence of	\$					-		
3/60,	ate be executed nysician and he burial-transit	<u>a</u>	that initiated events resulting in death) Last	,	a consequence of):							
O. BOX 68	The law requires that the death certificate to also has been signed by the ettending physic page 2 should be detached for use es the to also.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Fetal death	3 ⊟Ectopic 5 ⊟ Other (s					23	d. Date of deliv	ery Day Year
ds, P	uires that the de n signed by the e Id be detached f	þ	Part II. Other significant conditions con	ntributing to death b	out not resulting in t	he underlying	cause giv	en in Part I	l.		tobacco use		he cause of death?
Scor	aw requir is been si 2 should I	Completed				_				24a. Was	s an	24b. Were auto	opsy findings available impletion of cause of
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<u> </u>	ysician: is certific director.	Be	25. Was case referred to medical examiner?	le acital.			100		e of Death	Check only	one)		
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Division of Vital Records,	or Attending Physician: after death. Director: After this certifical in by the funeral director.	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be									al Poute Number	
2	To the Hospital or Attenwithin 24 hours after deat To the Funarat Director: completely filled in by the		4 Homicide determined 29a. Certifier Certifying Physics	building, et	c. (Specify)			no det		City or To	iwn, State)		
	n 24 hi he Fun pletely	edical	29a. Certifier Certifying Physical Examination (Circus only one)	ner: On the basis of and manner st	i examination and/	or investigatio	n, in my o	pinion, dea	id place, a ith occurre	and due to the ed at the time,	date and p	namer as s lace, and due t	o the cause(s)
1	To the within 2	ž	29b. Signature and title of certifier	n 1			c. Licens				1	signed (Month,	,
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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. IIAEI (ANE 4940 EASTERN AUE BEITHMORE, MD 21224 MICHAEL LA
31. Date filed (Month, Day, Year)
JUN 14 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician ам Bryson June 2006 3:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2 F Hours Min 215-38-5620 73 Yrs. Director June 11, Germany Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits i Hygiene. I other than "natural", or frema 23e or averagent, the Medical Evandrer must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 Adrian Street 20853 Germany filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No SpecifWhite δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County 12 Cafeteria Manager Public Schools injury or other traumatic event, permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event any injury or other traumatic event ange. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Wilhelm Schmitt Anna Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helga B. King/ Daughter 7279 Covingtons Corner Road, Bealeton, Virginia 22712 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State June 15, Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Ken Stile 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Glioblastoma Multiforme /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ettending physicien end that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 WNo Month Day 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cete has been signe page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 Yes 2X No 1 TYes 2∏ No funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice Certification: To 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1X Natural 5 Pending after death.

Director: Aft
d in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D35635 June 12, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 115 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 /Medical ranklin Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Lar.

7. Age (In yrs. last birthday)

Yrs. Sen hester town If Under 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 1□ M 2□ F 25,1941 Kentucky Months Days Hours August 64 404-56-5410 Director Usual Residence of Decedent e filed within 72 hours after deeth with the Maryland in Hygiene. other than "netural", or items 23a or 28e-f ehow 10a Slate 10c. City, Town or Location 10d. Inside City Limits rthan "netural", or itama 23a or 28e-f ehow the Medical Examinan must be multified at 1 Yes 2 No Louisa ⊵Kentucky Lawrence Direct 10e. Street and Number 10f Zip Code 10n Citizen of What Country? 41230 526 Highway 1395 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □ No Korea If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Automobile Chief Steward 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked ofth any linity or other treumatic event, potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della Layne Russell Biggs 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Highway 1395 Louisa, KY 41230 Buella Biggs/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/15/06 Louisa, KY Greenlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein, Newanm Chestertown, MD Suik anbein 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) **Physician** PROBABLY MOTHEROLOGOROTIC CARDIDONTOVIAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien end shed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, oulcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 00 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 €R/OutpatienI 3 ☐ DOA ၉ 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 2 in Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and blane, and due to the cause(s) and moment as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 6/09/06 10027509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES LACET, MC WATHINGTON AUS. CHOOGRIOWN. MO 32. Registra Signature 31. Date filed (Month, Day, Year) State JUN 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2043 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 **Physician** June Ardell Allen Bentley 2006 5:00 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 318 State Street Annapolis Anne Arundel 7. Age (In yrs. last birthday)
75 Yrs.

| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Min. | Jan. | 21, 11 5. Social Security Number Birthplace (State or Foreign Country) **Funeral 1**00 M 2 □ F 213-28-3075 1931 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1 √ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 State Street 21403 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 25No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President 12 Banking ... Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: if Item 27 ie marked other t ljary or other traumatic event, ⊞ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bentley Edna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Bentley/wife 318 State Street Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department of Important: if any injury or once. Ft. Lincoln Crematory 6/13/2006 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by sign 1 be DEMENTIA ALZHEIMERS 1 🗆 Yes 3 Probably 4 Unknown should CURONARY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate hes birector, page 2 s 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ ₩6 Other: 4 Nursing Home 5 U esidence 6 Other (Specify) ဥ After thi 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 6-13-2006 MOMPH D38326 PE-MARY CLANCE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPULIS MD 21401 PARICWAY MEPICAZ 2001 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 13 2006 Registrar

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06-03941 Please Type or Print in Black Indelible Ink Kevin Brinsley State of Maryland / Department of Health and Mental Hygiene 2006 204 is 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1708 hrs Medical Examiner KEVIN WAYNE BRINSLEY June 8, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 115 West Dover Street Easton Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director 19 218-13-6530 1**X** M 2 F FEB. 15, 1987 Country) MARYLAND Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1XX Yes 2 No TALBOT EASTON MD Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 9200 HONEYSUCKLE DRIVE 21601 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black Armed Forces? 1 X Never Married 2 White etc. Married Yes Widowed Divorced f Yes, Give Yea Yes 2 X No specify: Specify: WHITE ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical 21215-0036 LABORER CONSTRUCTION Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES WAYNE BRINSLEY BARBARA SHORES ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is r r traumatic 9200 HONEYSUCKLE DRIVE, EASTON, MD 21601 BARBARA J. NASH/MOTHER ent of Health and: If item 27 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 ABurial 2 Cremation 3 Removal from State WHITEMARSH CEMETERY 6/13/2006 TRAPPE, MARYLAND 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee PLLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA C.F.S.P. 71 Ustiesuski. Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? o contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 V No 3 Probably 4 Unknown leted 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of Compl performed' death? ✓ Yes 2 No 1 🗸 Yes of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ✓ Yes 28a. Date of Injury FOUND: Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred ion: Subject hanged himself FOUND: Division Natura Pending 1 Yes 2 V No Director: Certificat Jun 8, 2006 1655 hrs 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 🗸 Suicide Could not be or Town, State) 115 West Dover Street, Easton, MD determined (Specify) Jail/Penal Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E June 9, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year Registrar's Signar State ["]2009 Registrar

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Page Page net o			1 ☐ Burial 2 ☐ Cremation 3 (`4 ☐ Donation 5 ☐ Other (Speci			AKE CREMA	· 1	5/9/2006	STEVE	NSVII	LE, MD
Baltimore, Maryland 21215-5-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural, or I any injury or other traumatic event, he Medical Example.	once.		21. Signature of Funeral Pervice Lice	I cum D		22. Name and Addr FELLOWS, 1 200 S. HA		and the same of th			
		\dashv	23a. Part1. Enter the disease, or cor	nplications that cause	the death. Do not	enter the mode of dy	ing, such as cardiac	or respiratory ar	MD 216	OI.	Approximate
Pnysici	30		shock, or heart failure. List only Immediate Cause (Final	one cause on each i	ye. 		10/10				Interval Between Inset and Death
/Medic	cal		disease or condition resulting in death)	a. Due to (or as	a consequence of)	eurir	100			21	191
Examin			Sequentially list conditions	b. July	& dy	molition.	ms			7	mely
pe is			Sequentially list conditions, if any, Isaang to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)		1/1				1111
xecuti and II-tran		xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	a sy-	~ (3U; Y) Y				yeary y
68760 ficate be e physician is the buris				d							
		edic									
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 Ectopic pregnance	cv.			e of delive	
D. B. B. death he atte		SICIO	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant a 9□Unknown		5 Other (specify)			Mo	nth	Day Year
Records, P.O. Box The law requires that the death cer ate has been signed by the attendir		ל ל	Part II. Other significant conditions	contributing to death h	out not regulting in th	ne underhing eauce g	won in Part I	23e Did to	pacco uso cook	ibura ta th	e cause of death?
ds, lires to signe			1210/11	to the	MI 2	ie dilderlying cause g	voirii Fatti.				ably 4 Dunknown
Records, he law requires to has been signed age 2 should be		Completed	die	Mr 30 d				24a. Was	an 24h V	Nere autor	osy findings available
He ia he ia he has	5	duic -	e qu	16000				autop	rmed2	rior to con leath?	npletion of cause of
an: Tall		Φ :	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	-	□Yes	2 LI No
Of VITAL REC Physician: The law r this certificate has be		0	examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 Inpati	ent 2 ER/Outpa	atient 3 DOA		ome 5 Resid		ar (Specify)
ID O ing PI	5		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tim	ry Wo	ork?	28d. Describe h	ow injury occurr	ed	
Division of Vital or Attending Physician: after death. Director: After this certifica		cat	2 Accident investigation 3 Suicide 6 Could not	no -]Yes 2 □No	004 1 15 15			
OIVI I or All after a	6	Certification;	4 Homicide determined	building, e	c. (Specify)	, street, factory, office	,	28f. Location (S City or Tow	m, State)	ər or Hurai	Houle Number,
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Perueral Director: After th componenty filed in by the funeral			29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, o	eath occurred at the	ime, date and place.	and due to the d	cause(s) and ma	nner as sta	ated.
n 24 h	Cloton)	edical	(Check only 2 ☐ Medical Exa	miner: On the basis of and manner st	f examination and/o	r investigation, in my	opinion, death occur	red at the time, o	date and place, a	and due to	the cause(s)
To the withing To the company			29b. Signature and title of certifier	D) ////		se number		29d. Date signed	Month, L	Day, Year)
			Kyle	200	por	0 02	5750		6/8/	06	
-b-	A CONTRACTOR OF THE CONTRACTOR	1	30. Name and address of person who				D10mov v	m 01/01	, 1		
	State		ROBERT B. SANS 31. Date filed (Month, Day, Year)		OUS LDLEW rar's Signature	TED WAR.	EASTUN, M	m 51601			
Reg	otati gistra	-	JUN 1 2 20		w At A	and o					

		1 - For State Ragistrar		aryland / D		ent of H	lealth and		giene Reg. No.		201	1
Physic	ian	Decedent's Name (First, Middle, Last	st)					2. Date of De. Month	ath Day	Year	3. Time of I	
/Med Exami	cal	Ruth M. 4a. Facility Name (If not institution, give	Carter)	4b. C	ity, Town, or	Location of De	June	7 4c. C	2006 ounty of Death	9:00	р ^М
LAUIII		Millennium of Fo				restv				ince G		
Funeral		5. Social Security Number 6. S	9x 7. Aç	ge (In yrs. last birtl		der 1 Year	If Under 24 H		h	9. Birth	place (State or intry)	r Foreign
Director		376-20-3422	□M 2(X)F	85 Y	rs.	Days	Tiours Wil	July 6			th Caro	lina
and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City	v Limite
Aaryli Febo	5	Maryland Prince G	00700		estvil	1 .					1Ž Yes	•
the h	ect	10e. Street and Number	eorge	FOL		Zip Code			10a Citiza	on of What Cou		
with Sa or	0	1200 Waterford Dr	ino		10	207	7 / 7			an or winat cot	may:	
1.Z I 5-UU36 within 72 hours after death with the Maryland ane than "natural", or iteme 23e or 28e-f show the Medical Exercicer must be inclifted at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De			(Specify Yes or No erto Rican, etc.)	USA - 14	Race - Amer	ican Indian.	
after after	Ē	1 Never Married 2 Married	Armed Forces?					erto Rican, etc.)		Black, White		
Dones a	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ∐ Ye	s 2 X No	Specify:		S	pecify:	Black	
Z 1 Z 1 3-0036 ad within 72 hours attginen. or then "naturel", or the Medical Exam.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's U	Isual Occup	ation during most of w	rorkina	16b. Kind	of Business/I	ndustry	
if hin	ğ	Elementary/Secondary (0-12)	College (1-4or		life. DO NO	T use retired)					
led w		9		I	Homema	ker				wn Home	2	
Maryland of 2 should be file th and Mental Hy 27 is marked oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,				
hould d Me nark natio	2	Arthur Jones 19a. Informant's Name/Relationship (1)	Suma Print)	106	\$4-10- A dd	(011			ocker			
Man d 2 sl th an 7 ier					10.1			Rural Route Numbe				
Heal Heal	1 3	Delores Watts/Dau 20a. Method of Disposition	gnter	20b. Place of	Disposition (Name of		Forestvil		D 2074 Ition - City or T		
ages of of t: if if		1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery	, crematory of	or other plac	e) tery 6/				Marylan	ı.d
Daltimore, Maryland 212.15-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show piny or other traumatic event, the Medical Examinat monat be notified at any injury or other traumatic event, the Medical Examinat monat be notified at any pinge.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		1016 1		-	s of Facility	15/00	DICH	.wood,	riaryran	iu
Deperiment of the control of the con		> alpha	W. Me	lle	526F	Linco	ln Fune	ral Home Rd., Bre	ıtwoo.	d. MD	20722	
by F.C. BOX 00100, 100, 100, 100, 100, 100, 100, 1	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	imer's Di a consequence of a consequence of a consequence of	f): I):	, End	Stage				Interval Betw Onset and Do	eath
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US, T		Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlyin	g cause give	in in Part I.				he cause of decaded	
The law requires the law been signed as the law seen signed as the law seen signed by the law seen signed by the law seen seen seen seen seen seen seen see	Completed							24a. Was a autop perfor	sy med?	prior to co death?	opsy findings av	vailable use of
sian: srtific ctor,	Be (25. Was case referred to medical examiner?					26. Place of De	eath /Check only or				
hysic his o	ို	1 ☐ Yes 2 ♣ No	Hospital: 1 ☐ Inpatie		patient 3	DOA Othe	4K Nursing	Home 5 ☐ Resid	ence 6 [Other (Special	(y)	
ing P		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tii	me of ju ry	28c. Injury Work	at ?	28d. Describe h	ow injury o	ccurred		
Attending or death.	catl	2 Accident investigation 3 Suicide 6 Could not be			M		′es 2 □ No					
in or Attending Physician: 3 after death. Director: After this certificed in by the funeral director, p	Certification:	4 Homicide determined	28e. Place of Inj	ury - At home, farr c. (Specify)	n, street, fact	ory, office		28f. Location (S City or Tow	treet and M n, State)	lumber or Rura	al Route Numbe	er,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1X Certifying Ph (Check only 2 Medical Examone)	ysician: To the best iner: On the basis o and manner st	f examination and	death occurre or investigati	ed at the tim on, in my op	e, date and place inion, death occ	ce, and due to the courred at the time, of	ause(s) and pl	nd manner as s ace, and due to	tated. o the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier			2	29c. License	number	i i	29d. Date s	igned (Month,	Day, Year)	
		▶ (/@\\\\\\\\\\	milto,	\		D5152	20		June	8, 200)6	
R (4)		30. Name and address of person who o	M.D., 132	8 Souther		nue, S	S.E., #3	310, Wash	ingto	n, DC	20032	
St Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature								

		•	For State Registrar	State of N	Maryland		artment of F <i>rtificate of</i>		i Mental Hy ا	giene" 💆 🕻 Reg. No.	けいり	20	ing
	Dhysici	20	1. Decedent's Name (First, Midd	le, Last)					2. Date of De	ath Day	Year	3. Time of	Death
	Physici /Medio		Alice	Κ.		(Cox		June 8, 2	006		6:30A	М
7	Examin	er	4a. Facility Name (If not institution 5608 Janice Lane	n, give street and numbe	er)		4b. City, Town, o		eath	4c. County Prince		e's	
l	Funeral Director		5. Social Security Number 369–12–5061	6. Sex 7 1 ☐ M 3	Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		h	9. Birth	olace (State of ntry) higan	r Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	V	10c. City,	Town or Lo	ocation					0d. Inside Cit	ty Limits
	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28e-f ehow ha Madical Examiner must be mullied at	tor	Maryland Prince	e George's	Tem	ole Hil	1s					1 🗌 Yes 🕽	-
	or 28e	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	ath wil	raic	5608 Janice Lane				20748			USA			
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Rad Bla	e - Americ ck, White,	ean Indian, etc.	
36	urs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorce	If Yes Give			1 □ Yes 2,Ex No	Specify:		Specif	· Whi	te	
21215-0036	72 hou	sted	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	pation	vorkina	16b. Kind of B	usiness/In	dustry	
121	vithin han *	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work done DO NOT use retire Homemaker	d)	vorking	In H			
2	Hygie Hygie ther t		12 17. Father's Name (First, Middle	. Last)			Tionenaker	18. Mother's N	lame (First, Middle,				-
Maryland	ges 1 end 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-f ehow or other traumatic event, the Madical Examinar must be multified.	To Be	Charles R. Tait						h P. Lamble		.0,		
ary	shou and M a mar	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town,	State, Zip	Code)	
	end 2 eaith a n 27 is		Robert Niffenegge	er / Son					n, MD. 20639				
ore	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. Pla	nce of Dispo	osition (Name of matory or other pla	ce)	Date 12 2006	20c. Location	•		
Baltimore,	it. Pairtmen rtant: njury		4 □Donation 5 □Other (21. Signature Funeral Service		Cec		1 Cemetery	i		Suitland,	-		
Ba	permit. Pages 1 end 2 Depertment of Health at Important: if item 27 is eny Injury or other treu QDCe.		21. Signature granteral service	dy /			6160 Oxon	Hill Roa	George P. Ka d Oxon Hill	alas Fune , Marylan	ral Ho d <u> 2</u> 0	me PA 745	
			23a art1. Enter the disease of shock, or heart failure. Lis	r complications that caus t only one cause on each	sed the death. h line.	Do not ent	er the mode of dyi	ng, such as card	iac or respiratory ar	rrest,		Approximate Interval Bety	veen
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P.0	d by the	Phys	9 Unknown			tion of the state of			00- 0:4				
Records,	w requires the been signed I should be det	ted by	Part II. Other significant condit	ions contributing to death	n but not result	ting in the u	nderlying cause gr	∕en in Parti.		obacco use cont res 2 □ No	3 Prob		eath? nknown
Rec	The law r ate hes be page 2 sh	Completed					·		24a. Was autop perfo 1 □ Yes	rmed?	Were auto prior to co death? 1 Yes	psy findings a mpletion of ca	ivailable luse of
/ita	clen: ertific ector,	Be (25. Was case referred to medic examiner?						Death (Check only o	ZLIL			
of Vital	Physiclen: r this certifica ral director, p	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpe	atient 2 E	R/Outpatier	IL SELDON		Home To Resid			y)	
O	ding h. After funer	tlon	1 ⊠Natural 5 ☐ Pend	/A Annth	Day Year)	Injury	Wo	ryat rk?]Yes 2∐No	28d. Describe r	now injury occur	red		
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1	To the Hospitel or Attending Physicien: The lav within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical Co	(Check only 2 Medica	ing Physician: To the be if Examiner: On the basis	s of examination	ledge, deat	h occurred at the ti	me, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and madate and place.	inner as s	tated.	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifi	and manner	stated.		29c. Licen:	se number		29d. Date signe	d (Month.	Day, Year)	
	- s + ŏ		Facerure (d. lass.	- Lu	full	v. D.	180-	19	JUN.	5 8	, 2006	5
0	(15)		30. Name and address of person	who completed cause of	of death (Item 2	23a) (Type,	Print) Franc	ine Higgs	Shipman MD)			
	()		31. Date filed (Month, Day, Year	EUTSULLIG	PR istrar's Signatu	1	386756	RUIS,	un	2070	2		
	Sta Regist			2006 22 Hegi	Suar S Signatu	Lan	E	V					

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artmen rtificat				lental Hy	/giene Reg. No.	006	20420
2	Physici	an	1. Decedent's Name (First, Middle, Las		COCHR	AN				2. Date of De Month	eath Day	Year 2006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give Anne Arundel Medical	street and number)		4b. Cily,	Town, or apolis	Location of	of Death			County of Dea	ith
	Funeral Director		233 34 7540	7. Age	(In yrs. last birthday) 70 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, Di Pebruary	rth ay Year 19	36 9. Bi	thplace (State or Foreign ountry) St Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or Lo	ocation			-				10d. Inside City Limits
	e Many	ctor	Maryland Prince Geo	rge's	Clinton								1 ☐ Yes 2XXNo
	s with th	I Dire	10e. Street and Number 6814 Groveton Drive			10f. Zip	2073	35			-	zen of What C SA	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other traumatic event, If a Medical Exercical mont be rollified at ance.	by Funeral Director	11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes % XXXX If Yes, Give Year or Dates:	0	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)		4. Race - Am Black, Whi	
21215-0036	in 72 ho "natur legical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usua kind of wo DO NOT us	rk done d	<i>luring</i> mos	at of worki	ng	16b. Kir	nd of Business	/Industry
212	d with giene. er ther	Somp	Elementary/Secondary (0-12)	College (1-4or 5-	Heavy 1		·		r			Constru	ction
pul	be filed itat Hygi od other	Be	17. Father's Name (First, Middle, Last)			1 1		18. Mothe	er's Name	e (First, Middle			
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	and 2 sealth an n 27 ls		Mary Ann Cochran / W			-				ı, Maryla			219 0008)
Baltimore,	of Hex of Hex If item or othe		20a. Method of Disposition 1√√ ∯urial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	sition (Nan	ne of ther place	9)	С	Date	20c. Lo	cation - City or	Town, State
Ħ,	t. Pages rtment of I rtent: If it		4 ☐ Donation 5 ☐ Other (Specify) /	Trinity Mer		4 4 4 4	4 F 115	4			orf, Mar	·
Ba	permit. Depertr Imports any in		21. Signature Funeral Service Licen	clas h	\	2. Name an 6160	Oxon	Hill]	^{ry} Geor Road (ge P. Ka Xon Hil	alas F I, Mar	uneral H yland 2	ome PA 0745
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3760,	ate be executed sysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
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of Vital	Physician: this certificated ral director, is	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ☐ ER/Outpatie		Othe			(Check only	-		
n of	ng Phy Iter this	on: To	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day			8c. Injury Work			me 5 Res 28d Describe			эсігу)
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	To the Hospitel or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one) Certifying Ph 2 Medical Exen	ysician: To the best of niner: On the basis of and manner sta	examination and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	nd place, ath occurr	and due to the	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier	Patri	in		c. License		201	120		signed (Mon	
,	(12)		20 Name and address of	omaka	anth (Ita- 22s) 7	Deigh		()	V(4	758	J	ne o	1006
C	200		30. Name and address of person who was a company of the company of	CLENT	eath (Item 23a) (Type,	PD	EFE	WSE	He	SHWA	Pa	NAPUL	2006 SMD21401
- 1	Sta Regist	ate rar	JUN 1 3 2006	De. Hagistia	& Asset	E)							

State of Maryland / Department of Health and Mental Hygiene 👱 🗓 🗓 🖔 20421 For State 6-21-06 State 6-21-06 Registrar Amend#'s17.18.19.200 F.H PCC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, 2006 12:35p M June Kouakou Yapi Claude /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F 44 Yrs Director 579-23-2185 August 17, 1961 Ivory Coast Usual Residence of Decedent toa State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Gaithersburg Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 United States 18329 Lost Knife Circle Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Loan Officer Banking permit. Pages 1 end 2 should be filed v
Department of Health and Mental Hygie.
Important: if Item 27 is marked other ti
eny injury or other traumatic event. Itaa 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be -Bickoua Suxane Bickoue Suzanne Kouakou Gaston Kouakou Baston 19a Informant's Name/Relationship (Type, Print)
Patricia Kouakou
Patrician Kouakou/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18329 Lost Knife Circle; Gaithersburg, Md. 20886 20b. Place of Disposition (Name of July 15,2006

20c. Location - City or Town, State Abidjan, Abidge, Ivory Co 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State Ivory Coast 4 ☐ Donation 5 ☐ Other (Specify) Yopougon Cemetery 21. Signature of Funeral Se 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Wa 20747 Forestville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6/2/06 Intracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner unknown Malignant Hypertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires thet the death certificate be executed signed by the ettending physicien and dbe detached for use as the burial-transit Acute on chronic renal failure unknown Due to (or as a consequence of): 6/8/06 Physician/Medical Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Hinknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 ⊠Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2 TNo ð this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö To the Hospital within 24 hours a To the Funerel Completely filled 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 2006 629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petek Donmez, M.D. 11119 Rockville Pike; Suite 401, Rockville, Md. 20852 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 1 6 2006 Registrar

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		1	For Stata Registrar	tate of Maryland		rtment of F tificate of			giene 2 Reg. No.	006	2042
	*		Decedent's Name (First, Middle, Last)					2. Date of De		Vone	3. Time of Death
ı	Physici	_	Judy Crawford					June	Day 15. 2	Year 006	1:00 a M
M	/Medic Examin		a. Facility Name (If not institution, give stre			4b. City, Town, o	r Location of D			unty of Death	
1	Examin	G1	5208 Belgreen Stre	et #301		Suitla	ınd		Pr	ince G	eorges
Н	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th v Year)	9. Birth	place (State or Foreign
	Director		251-92-7282	² □xF 56	Yrs.	MOIIIIS Days	riours	May 5	1950		City, S.C
	D		Jsual Residence of Decedent	1.0.00							10d. Inside City Limits
	rylan how		10a. State 10b. County		Town or Loc						1 √2 Yes 2 □ No
	e Ma	cto	Maryland Prince Ge	orges S	uitlan			r			
	be filed within 72 hours after death with the Maryland atal Hygiene. all Hygiene. do other then "neturel", or iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
	23a	le l	5208 Belgreen Stree	t #301		20746				ed Sta	
	r dea	Funeral	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	5. 13. V	las Decedent of I Yes, specify Cub	tispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14.	Race - Amer Black, White	
36	or it	Y F	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give	1	☐ Yes 2☐ No	Specify:		Sp	ecity: B1a	ck
21215-0036	72 hours aft "neturel", or	Completed by	3 Widowed 4 Divorced	Year or Dates:					16h Kind	of Business/I	aductor
7	net roller	lete	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of	working	100. Killu	01 003111633/1	ndustry
12	withir ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)							.
7	0.0		17. Father's Name (First, Middle, Last)		Adm1	nistrati		LS LATI L Name (First, Middle		ernmen mame)	
and	d of the t	Be					Luver	ain Dulmo			
Ž	12 should be filed within and Mental Hygiens 7 10 marked other then "reumatic event, the Mark	ပ္	Adam McKnight 19a. Informant's Name/Relationship (Type,	Print)	19b Mailin	a Address (Street		nia Fulmo r Rural Route Numb		own. State. Z	ip Code)
Maryland	s 1 end 2 should f Heelth and Men Item 27 le marke other treumatic		Charles A. Crawfor					#301 Sui			20746
	9 B E E		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of		Date		ion - City or 1	Town, State
٥	in in in in in in in in in in in in in i		1 Burial 2 ☐ Cremation 3 ☐ Rem	loval from State		natory or other pla	1	20 2006	Land	dover,	Md
Baltimore.	Then Then Tuny		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	нагі		Name and Addre		ne 20,2006	Lan	dover,	riu.
Ba	permit. Pages 1 Department of H Importent: If Ite eny injury or ott		North O. De	en MOID	75-	Alexan de	Iboro P	Pre Funera		es, Md:	A. ₂₀₇₄₇
			23a. Part1. Enter the disease or complical shock, or heart failure. List only one	tions that caused the death	. Do not ente	er the mode of dyi	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	Lung Cance						And And	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ							
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d	ate be execut hysicien end the burial-trar	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					1	
8760	ate be enthysicien	dicai	d								
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Box	ath certific	N/N	23b. Was decedent pregnant	. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	cv		230	d. Date of deli	
	deatl	icia	in the past 12 months? 1 ☐ Yes 2XX No	4☐Pregnant all time of de		Other (specify)				Month	Day Year
Division of Vital Becords, P.O.	The law requires that the death certific the law requires that the death certific ste has been signed by the ettending page 2 should be detached for use as	Completed by Physician/Me	9 🗆 Unknown	9 Onknown							
1	es the igned be del	y P	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
Ţ	quire an sig	ed t	Diabetes					_ 10	Yes 2□I	No 3∏Pro	obably 4 📆 Inknown
0	aw requ	plet	Hypercholesterol	emia				24a. Was	an a	24b. Were au	topsy findings available completion of cause of
ď	The lav	E						perf	ormed? 2√2 No	death?	2 No
4	icien: Th certificete rector, peg	BeC	Hypertension 25. Was case referred to medical				26. Place of	Death (Check only	25		
5	Attending Physicien: r death. ector: After this certifice by the funeral director, i	To B	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2	ER/Outpatier	t 3 DOA	her: 4 🗌 Nursi	ng Home 5 🖳 Res	idence 6	Other (Spec	city)
7	eral in		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at	28d. Describe	how injury o	occurred	
	e fat in a	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Manus, Day 7 CL)	()		Yes 2 No				
i.	or Attending Phy after death. Director: After thi	=	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office)	28f. Location City or To	(Street and fown, State)	Vumber or Ru	iral Route Number,
Ē	s afte	Certification:		Building, Sto. (Speen)	,,						
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the th			cian: To the best of my known: On the basis of examination							
	in 24 in 24 he Fi	Medical	one)	and manner stated.							
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	26			nse number			signed (Monti	
			1 XXXXXX	Marin	1//	D00	030296		June	15, 2	.006
)	II		30. Name and address of person who com		23a) (Type,	Print)	+1004	Md. 2074	6		
_	<u>U</u>		Debra M. Thompson	•		Way Sui	cland,	rid. 20/4			
		ate	31. Date filed (Month, Day, Year)	22. Registrar's Signa	ture	1/2					
	Regis	trair	JUN 1 6 2006	ALDEDE PE	Maria						

State of Maryland / Department of Health and Mental Hygiene 2042 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}**2006** Year **Physician** Bertie Rosettar Thomas Cromwell June 12. 9:50 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anna Arundel Medical Center Annapolis Anna Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Yea 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2XF 218-12-9543 85 Yrs August 6, 1920 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f show Examiner must be notified at Director Maryland Anne Arundel Severna Park 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 831 Ritchie Highway; Apt. 414 21146 United States Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
shart if item 27 is marked other then "naturel", or items 23, and other fraumatic event, its Medical Exprimental any or other fraumatic event, its Medical Exprimental Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) Coltege (1-4or 5+) 10th grade Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Guie Thomas ဥ Annie Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caralis Roman Kimbrue (Grandson) 2501 Dog Leg Drive; Crofton, Maryland 21114 20b. Place of Disposition (Name of Semetery, Crematory of other place)

Asbury-Broadneck United June 19, 2006

Methodist Church Cemetery Annapolis, Mary 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. 4 Donation 5 Other (Specify) Annapolis, Maryland 21 Signature of Funeral Service Light 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 822 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation Injury death 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by it 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 06 3999 MOTANE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi, M.D.; 2001 Medical Parkway; Annapolis, Maryland 31. Date filed (Month, Day, Year) State JUN 1 6 2006 Registrar

20424 State of Maryland / Department of Health and Mental Hygiene, 110 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JUNE 8 Pay **Physician** GEORGE PRESTON CHEERS 2006 15:15 P M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 8. Date of Birth (Month, Day, Year) 9 DEC. 5, 1939 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□ F 66 MARYLAND 217-36-2108 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10h County r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at CENTREVILLE 1 Yes 2 No MD QUEEN ANNE'S Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 BROWNSVILLE ROAD 359 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TD Yes 2 □ No If Yes, Give Year or Dates:1959-1965 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or iten eny injury or other freumatic event, the Medical Examinar 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Second 10 condary (0-12) College (1-4or 5+) TRUCKING TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be "UNKNOWN" BEULAH JOHN CHEERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 BROWNSVILLE ROAD CENTREVILLE, MD 21617 MARTHA COOPER CHEERS/ WIFE Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARYLAND VETERAN 15 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2006 HURLOCK, MD 3 Removal from State CEMETERY 21. Signature of Fyneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A 408 SOUTH LIBERTY STREET CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as consequence of): cercin ama disease or condition resulting in death) /Medical Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien end thed for use as the burial-transit disc caper weesk SONEN that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) signed by the at id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ünknown 1 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificete 2 0 No 1 Yes 25 Physician: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2000 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending ↑ Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D51735 MD

State Registrar

DHMH 17 Rev 1/2001

2 2006 JUN 1

SICK 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HILL Rd Chestertaun MD Registrar's Signature

			1 - For State Registrar	State of Ma		l / Depa	artmer	t of H						201	125
	K 8	2	1. Decedent's Name (First, Middle, Las	st)							2. Date of De			3. Time	of Death
н	Physicia		Katherine Louise	Collins-C	Granad	los					June 9	9, 2	ay Year 006	5:00	РМ
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of				c. County of De	ath	
			4908 Continental	Drive			01ne	у				M	ontgome	ry	
	Funeral		Social Security Number 6. S	өх 7. Age	e (In yrs. la	st birthday)	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, Da	rth a <i>y, Yea</i>	9. Bi	rthplace (State	or Foreign
	Director		218-38-9461	L M ZLAF	94	Yrs.					10/5/1	1911		hington	, DC
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	ocation							10d. Inside (City Limits
	Aaryla sho	ö													s 2 No
	28a-	ect	Maryland Montgon 10e. Street and Number	iery	01ne	еу	10f. Zir	Code				10g. C	itizen of What C	Country?	
	with a or	Funeral Director	4908 Continental	Drivo				832				USA		,	
	Jeath	era	11. Marital Status	12. Was Decedent I	Ever in U.S	13.			spanic Ori	gin? (Spec	cify Yes or No lican, etc.)		14. Race - Am	nerican Indian,	
(0	r itar	F	1 Never Married 2 Married	Armed Forces?	10					i, Puerto P	lican, etc.)		Black, Wh	ite, etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or itams 23a or 28a-f show the Madical Exeminer must be maillisd at	by	3 XWidowed 4 ☐ Divorced	tf Yes, Give Year or Dates:			1 🗌 Yes	2 <u>X</u> No	Specify:				Specify: W	hite	
5-0	72 honatu	Completed	15. Decedent's Education (Specify only highest graduations)			16a. Dece	dent's Usu	al Occupa	ation during mos	t of workin	a	16b.	Kind of Busines	s/Industry	
2	of the	du	Elementary/Secondary (0-12)	Cottege (1-4or 5	+)	life.	DO NOT L	se retired)		-				
2	ygier ygier her th			2		Secre	etary		10 11-11-	-d- N	/C' 14'-14'	-	vitt &	Sons	
ind	be fi	Be	17. Father's Name (First, Middle, Last,								(First, Middle	, Maide	in Sumame)		
3	J Mer Dark Park	J.	Michael A. Collin 19a. Informant's Name/Relationship (10h Maili	Add	- (Ctrant		Edwa		Cit.	or Town, State,	Tin Cordal	
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28a-f show amy injury or other traumatic svent, the Marical Examiner must be notified at 205e.		Ramon Granados/ S				_						20832	Zip Code)	
	1 an Heat		20a. Method of Disposition	7011	20b. Pta	ace of Dispo	sition (Na	me of	1		ate		Location - City of	or Town, State	
Baltimore,	eges ant of t: If i		1 X Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			metery, crei + T -in ∧			1	n6 /13	/2006	Bro	ntwood,	MD	
Ħ	orten orten injur		21. Signature of Furteral Service Liger		FOL								ns Fune		
Ba	Depermination of the second of		1 LAM	_									D 20715	101	
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	ne. Typu	ordin		2	17. 6		respiratory a	arrest,		Approxima Interval Be Onset and	etween
	Examiner			Due to (or as	a conseque	ence of):								1	
	pe is	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque	ence of):		<u>-</u>							
,092	te be executed ysicien and te burial-transit	i Examiner	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):									
687	physic physic the k	dicai	•	d											
Вох	that the death certificate be executed to by the ettending physicien and detached for use as the burial-transit	by Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	déath 3[⊒Ectopic p ⊒ Other (s						23d. Date of d Month	elivery Day	Year
P.O.	requires that the een signed by th hould be detache	Ph	Part II. Other significant conditions	ontributing to death b	ut not resul	Iting in the u	inderlying	cause give	en in Part I		23e. Did	tobacco	use contribute	to the cause of	death?
Records,	v requires been sign should be	Q D									10	Yes	2 12 No 3 □ 1	Probably 4]Unknown
CO	~ 0 10	Completed									24a. Was	an	24b. Were	autopsy findings	s availabte
Re	The law ete has page 2 (Ĕ										ormed?	prior to	completion of	cause of
Vital	ician: Th certificate rector, pag	Ü	25. Was case referred to medicat						26 Place	of Death	1 ☐ Yes (Check only	2 ETN	10 1 Ye	s 2 No	
5	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatie	nt 3□ D	OA Oth	or	•			6 □Other (Sp	ecify)	
o l	g Phys er this eral dir		27. Manner of Death	28a. Date of Inju	ry	28b. Time o		28c. Injun World	/ at		8d. Describe			,7	
Ö	ath. r: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		y roar,	прыту	м		Yes 2	No					
Division	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: Affer it completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Initial building, et			reet, factor	y, office		2	8f. Location City or To		and Number or i	Rural Route Nui	mber.
	e Hospit 24 hour e Funere	Medical (29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best miner: On the basis o and manner st	examinati	vledge, deat on and/or in	th occurred estigation	at the tin	ne, date an pinion, dea	nd place, a oth occurre	nd due to the d at the time	cause , date a	s) and manner and place, and de	as stated. ue to the cause	(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier	n			29	c. Licens	e number	1		29d. D	ate signed (Moi	nth, Dey, Year)	1
			- Clurker	facher	7			DE	57 19	2		J	العاما	2,200	>6
_			30. Name and address of person who			23а) (Туре	Print)	0-1	^	1 .1	A .		> 1	26	837
			Christophes ?			18	111	I'M	ce P	milip	1000	re	Olney	, un	7
	St: Regist		31. Date filed (Month, Day, Year)	2006 32. gistr	ar's Signati	ure	Carlo								

20426 State of Maryland / Department of Health and Mental Hygiene) [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year 8:55 AM **Physician** an son 2006 mala /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Montgomery Riderwood Village 8. Date of Birth (Month, Day, Year) 06/29/1922 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1፟M 2□F Hours Yrs. 471-16-9637 83 Minnesota Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23a or 28a-f ehow tre Medical Examiner must be notified at 1X Yes 2 □ No Silver Spring Maryland Montgomery Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA Apt. 113 3122 Gracefield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 143-146 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NASA Electrical Engineer 5+ traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental h Alice Mary Johnson Nels Johan Carlson and ! 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Heelth a ent: If item 27 is 3122 Gracefield Road Apt. 113 Silver Spring, MD Betty Carlson/ Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any injury or once. ö 06/15/2006 Waldorf, MD * 4 □Donation 5 □ Other (Specify) Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service I de 16000 Annapolis Road Bowie, MD 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Menocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, sign d be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: No. 3 DOA 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٥ 1 🗌 Yes After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Pendina 16 Natural 1 Yes 2 No death. 2 Accident nerej Diractor: , filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after To the Hospital within 24 hours a To the Funerei C 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 66 D0043375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd. Silver Spring, MD 20904 Merritt, M.D 32. gistrar's Signature 31. Date filed (Month

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrer AMEND # 236,c 246, 2	State of Marylan	d / Depa ы ы <i>Сег</i>	artmen <i>tificati</i>	t of He e <i>of D</i>	alth and I eath		giene Reg. No.	2006	20427
			Decedent's Name (First, Middle, Last)	COCT OF THE PROPERTY					2. Date of De	ath	Van	3. Time of Death
	Physici /Medic	4	William Henry	Carter					June 1	.2. Day		10:00 P M
june Je	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or L	ocation of Death)	4c.	County of Deat	th
			Southern Maryland					Clinton				George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2 ☐ F		If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Bird	thplace (State or Foreign buntry)
+	Director		Usual Residence of Decedent	73	3 , ,,,,,				April	21,	1933 N	Maryland
	land	Ì	10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Man	ţċ	Maryland Prince G	eorges	Е	3rand	ywine					1 ☐ Yes 2) (☐ No
	in the	Director	10e. Street and Number			10f. Zip				10g. Citiz	zen of What Co	ountry?
	23a d		8508 Oak Drive					20613			USA	
	tems tems	Funeral		Was Decedent Ever in U Armed Forces?	.S. 13. V	Nas Deced f Yes, spec	dent of Hisp cify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes or No Rican, etc.)	- 1	 Race - Ame Black, Whit 	
36	within 72 hours after death with the Maryland ene. then 'natural', or items 23a or 28a-f ehow the Madical Examinar must be notified at	by F	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	1 □ Yes	2 🔀 No	Specify:			Specify:	White
8	hour	edt	15. Decedent's Educ		16a. Deced	dent's Usua	al Occupation	on		16b. Kir	nd of Business/	/Industry
215	nn 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of wo DO NOT us	rk done dui se retired)	ring most of wor	king			,
212	d with	Completed	6	Oonege (1-401-5+)		Mecha	anic			Н	leavy Ed	quipment
9	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. I marked other then "natural", or Itema 23a or 28a-f e-how matic event, the Medical Examinational be notified at	Be	17. Father's Name (First, Middle, Last)				1	8. Mother's Nan	ne (First, Middle,	Maiden	Sumame)	
<u>ya</u>	should be f and Mental H marked of umatic eve	2	Pearl Elsby Carter						_ynn Sud			
Maryland 21215-0036	2 sh and ie m	1	19a. Informant's Name/Relationship (Typ	·	Ti statutation	11.73287.354			ral Route Numbe	W406 69		Zip Code)
e)	1 and dealth om 27		Katherine E. Carte 20a. Method of Disposition	r - Wife	8508	Oak	Drive	e. Brane	lywine,_ Date	MD 2	0613 cation - City or	Town State
ဝို	ages nt of lit.		1 Å Buria 2 ☐ Cremation 3 ☐ Re	moval from State	Place of Disposemetery, crem							
Baltimore,	artme orteni Injury		4 Donation 5 Other (Specify) 21. Signature of Fun of Salvid Licensee					y 6-17			land, M ashingt	
B	permit. Peges 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic e <u>once</u> .		NAILEIS	& facult				•				, MD 20604
			23a. Part I. Enter the disease, or complic	ations that caused the deat						<u>-</u>	4.40	Approximate Interval Between
1	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition		OCAR	DIAL	- IN	FARCT	Dal			Onset and Death
K	/Medical		resulting in death)	Due to (or as a conseq	uence of):	,,,,	,,,	VFARCT				
	Examiner		Sequentially list conditions, b.	Core	WARY	AI	rter	y DIS	EASE			
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	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	rtens	ron						
8760	cate be executed bhysician and the burial-transit	dical E			, .							
687	ficate p physical as the		d.									
Вох	eath certific attending p	N/M	1F FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna		Tatania ar		NA		2	3d. Date of del	ivery
œ.	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown]Ectopic pr] Other (sp					Month	Day Year
<u>о</u> .	that the de led by the a detached i	hys	9 Unknown								-	
	8 P 0	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying c	ause given	in Part I.			_	the cause of death?
ord	w require been sij should t	Completed							101	′es 2 €		obably 4 Unknown
ခ္က	e law has b	np(24a. Was autop		24b. Were au	topsy findings available completion of cause of
a									1 ☐ Yes	2 No	1 ☐ Yes	2 No #/A
⋚	Attending Physicien: r death. ector: After this certific by the funeral director, i	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 🖼	ER/Outpatien		Other		th (Check only o			
ō	Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Bc. Injury a Work?		ome 5 Resid			city)
<u></u>	ath. r: Afte	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м		s 2 □No				
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory	, office		28f. Location (S City or Tow	Street and	Number or Ru	ıral Route Number,
ā	itel or A											
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Madical Examina	cian: To the best of my kno ar: On the basis of examina	wledge, death tion and/or inv	occurred restigation,	at the time, in my opin	date and place ion, death occu	and due to the orred at the time,	ause(s) a date and	and manner as place, and due	stated. to the cause(s)
	ithin 2 the mplet	Med	29b. Signature and title of certifies	and manner stated.	-	290	. License n	umber		29d. Date	signed (Mont)	h, Day, Year)
	₹. <u>₹</u> %		1/1/	6-		(-	D411	82		6	113/1	26
5			30. Name and address of person who con	npleted cause of death (Item	23a) (Type	Print)	- (())			-	FI	· WASHINGTONIA.
,	Bb		Feltun Ander		9	400	LIV	ingstor	Rd	Sic,	k 35	n. Day, Year) OB WASHINGSTURIAL DZO 744
	Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's Signa	iture	1 10						
	Registr	ar	JUN 1 6 20	106 Steens	N RE	A STAN	P					

James Augustus Chaporis

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2005 20420

		Registrar Certificate	ΟĪ	Death			Reg N	lo.	
Physicia ledical Examin	11	Decedent's Name (First, Middle, Last) James Augustus Choporis				2. Date of De Month June 11,	Da		3. Time of Death 1941 hrs
		Facility Name (if not institution, give street and number) 21768 S. Coral Drive	4	b. City, Town, or Lo Lexington Pa		ath		4c. County of Dea St. Mary's	th
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. last birthday)	_	If Under 1 Year Months Days	If Under 24H Hours M	Irs. 8. Date of E	irth (M	M/DD/YYYY) 9. B Fore	
Director	-	215-70-9544 1 X M 2 F 46	rs.	Mortano	Tiodro IV	03/10)/19	960 °	ountry) Maryland
' any	t	10a. State 10b. County 10c. City, Town or Loc	catio	on I.					10d. Inside City Limits
ne Maryland or 28a-f show fied at once.	힕	Maryland Prince Georges 10e. Street and Number	_	Leonardt	own Bowie		10		1 Yes 2 X No
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	39982 Ben Morgan Rd.			715 20			Citizen of What Co	•
ath with the litems 23a	╼┕	11. Marital Status 12. Was Decedent Ever in U.S. 13. V		Decedent of Hispa es, specify Cuban, N	nic Origin? (Specify Yes or N		14. Race - Ame White, etc.	rican Indian, Black,
P P E		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year		Yes 2X No		to Mean, oto.,			White
hours after "natural", Examiner	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	lent	's Usual Occupation ost of working life. D	n (Give kind o		16b	o. Kind of Business	
136 hin 72 h ethan "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Operator			T	iguor Sta	re
21215-0036 July be filed within 72 Mental Hygiene marked other than 't		17. Father's Name (First, Middle, Last)	_ /		.Mother's Nar	me (First, Middle,			
2121 Jid be f Mental markec : event,	To Be	Demosthenes Paul Choporis 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling	Address (Street a		Greenwe		City or Town Stat	e Zin Code)
MD 21 d 2 should 1 Ith and Mer n 27 is man	-			Glebe La					
s l an if Hea			osil	tion (Name of ceme		Date		c. Location - City o	
Baltimore, permit. Pages I ar permit. Pages I ar Department of Here Important: If the injury or other tr	-	4 Donation 5 Other Specify: St. Fran	ci	s Xavier	6-	16-2006	Le	onardtow	n, Maryland
Bal permi Depar Impo	1			ame and Address o	ъ.				Home, P.A. ID 20650-0279
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.							Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Sharp and Blunt Force Injuries							Death
Andread and the second	1	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,							
	jiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
Scuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			 :				
execu an and		UNPENDED X AMENDED item#1,perME,CS5	57,	7/15/06 TT	Amond #	10b-f Dow	TAT .	G858 8/17/	OK TI
68760, ertificate be ding physici e as the buri		F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2		al death 3	Ectopic preg			23d. Date of deliver	ry
		past 12 months? 4 Pregnant at time of death 5		er (Specify)	JECTOPIC Preg	riaricy		MOUTH	Day Year
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ires that the signed by the detact	d b					1 Ye	s 2	✔ No 3 Pro	bably 4 Unknown
of Vital Records, ng Physician: The law requir frer this certificate has been so neral director, page 2 should	Completed					24a. Was auto	psy	prior to	utopsy findings available completion of cause of
tal Rec	틩.			·		1 Yes	ormed 2	? death? No 1 Y	es 2 No
Vital hysician: this certif	<u>ا</u> ۵	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	ent		her Nurs	k only one)	Resi	dence 6 🗸 Othe	er: Scene
J of V	욘	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of					how i	njury occurred	
Division tal or Attendir rs after death. al Director: A led in by the fu	gatio	2 Accident Investigation Jun 11, 2006 1943 hrs	-		2 V No				
Divi: pital or / ours after eral Dire	Certification:	3 Suicide 6 Could not be determined (Specify) Fire station	reet	t, factory, oπice buil	aing, etc.	or Town,	State)	and Number or R Drive, Lexinto	urat Route Number, City n Park, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence only				nd due to the cau	se(s) a	and manner as sta	rted.
To the I within 2 To the I complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated 29b. Signal/are and title of certifier	gatii	on, in my opinion, d		at the time, date		d. Date signed (Mo	
	_	(ural Hallan		O.C.M.				ne 12, 2006	onin, Day, real)
3	ŀ	30. Name and address of person who completed cause of death (Item 23a)	_				_		
5	ofe	Carol Allan, MD Assistant Medical Examiner 111 Peni 31. Date filed (Month, Day, Year) 32. Registrar's Signature	n S	treet, Baltimor	e, MD 212	01			
Sta Registi		NIN 2 9 2006	2	_				·~········	
DHMH 17 Rev 1/20	01	ORIGIN	IAL						

State of Maryland / Department of Health and Mental Hygien [1] For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** JOSEPH G. CAMIEL 7:20 P M JUNE 8 2006 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 118 TEAL CIRCLE OCEAN PINES WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F - 77 Yrs. <u>PENNŚ</u>YLVANIA 1929 Director 160-32-0374 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Directo OCEAN PINES MARYLAND WORCESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 118 TEAL CIRCLE 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Modical Examinat ORCE. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ۾ 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATE AUDITOR 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) NAGURNA JOSEPH CAMIEL ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 TEAL CIRCLE, OCEAN PINES, MARYLAND 21811 MARY A. CAMIEL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 6/13/06 DELMAR, DELAWARE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01343 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician IUNG 4121 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usbase or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Dther (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel o within 24 hours atl To the Funeral Di completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Durker 9733 Herl Thury 9733 Herlthury 32. Amistrar's Signature 31. Date filed (Month, Day, Yeer) State JUN 13 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Joseph Cornelious Cornell, Sr. 10:35p 15 2006 06/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Manchester Carroll Long View Nursing Home If Under 1 Year | II Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **X**☐ M 2 ☐ F Yrs 70 216-32-1464 Director 11-12-1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland beatment of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural" ~ " any injury or other treumetic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☐ No Director Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2206 Reese Road 21157 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☑ Married 1 XYes 2 □ No 1954-1 ☐ Yes 2 No Specify: Specify: Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced 1957 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carroll County Elementary/Secondary (0-12) College (1-4or 5+) Weigh Master Government 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Stump Herbert Cornell Mildred 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph C. Cornell Jr. - Son 673 Lake Drive, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Westminster, MD Patapsco UMC Cemetery 06-19-06 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens 934 South Main St., Hampstead, MD 21074 otome MOO550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cong Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed the attending physician and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 🗌 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 06 H0061206 J434 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) P 21102 MANCHESTER Griotis 1KE HANOVER Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 19 2006

State of Maryland / Department of Health and Mental Hygien 2043 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June June **Physician** 2^{Day} 2006 0235 Thomas Joseph Case /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Westminster Carroll Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 16 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 10XM 20 F Yrs. PA 53 219-58-3444 Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10a State 10h Counts itsm 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Mcclical Examinar must be notified at Carroll Westminster 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 95 Marhill Ct USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygene. Important: If item 27 is marked other then "naturel: or item any injury or other traumatic event." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Highway College (1-4or 5+) Elementary/Secondary (0-12) Administration Transportation Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Alice Barber Thomas Joseph Case, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Schrenker-Case/wife 95 Marhill Ct Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Carroll Cremation, Inc 6/22/2006 Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature Final Sovice Licens ²²Pritts^{Actess of Facily} Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cell () 26 SANCER -Small VON **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the at id be detached fo 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 □ Yes 2 □ No Completed peen 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? page 2 s Netrotos 13 certificate UVER 2□ No 1 Yes 2 □ 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes No Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27, Manne of Ceath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerei Director: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Yousuf Gaffar, MD dress of person who completed cause of death (Item 23a) (Type, Print) 34MINSHE, NO 2/15); Cente stret, 31. Date filed (Month, Day, Year) State JUN 2 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiené 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 10 2006 CHARLES CARROLL CONNOLLY, JR. 12:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13250 LEWISTOWN ROAD **QUEEN ANNE** TALBOT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F FEB 3 1917 89 MARYLAND Director 217-36-0028 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County item 27 is marked other than "neturel", or items 23a or 28e-f show other treumatic event, the Madical Examination in the notified at 1 ☐ Yes XXNo Director TALBOT **QUEEN ANNE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13250 LEWISTOWN ROAD 21657 death Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H is marked oth Be CHARLES CARROLL CONNOLLY, SR. ANNA AMELIA SLAUGHTER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 4010 CLOVERLAND DR., PHOENIX, MD 21131 Health em 27 CHARLES FENTON/EXECUTOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State ö Depertment of Importent: if any injury or once. SPRING HILL CEMETERY | 6/14/2006 EASTON, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 7 CHOT 200 S. HARRISON ST EASTON, MD 21601 MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Cancer Immediate Cause (Final ancreatic Physician monoth disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 40 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **1**No 1 ☐ Yes of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 1 No Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 24 hours a 29a. Certifier 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52016 Somma, M.D. Wasel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street # 6551 Samara 200 E. Waler 33 31. Date filed (Month, Day, Year) JUN 1 5-2006 Registrar's Signature Registrar

Phy	sician	
/M	ledical	
Exa	miner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic event, are Mudical Examinational most be notified at once.

Baltimore, Maryland 21215-0036

Langston

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, State Registrar

1 - For State Registrar	State of Maryla		rtificate of l			Reg. No.	
1. Decedent's Name (First, Middle, Last LANGSTON C.	DAVIS				2. Date of Dea JUNE	10 200	3. Time of Death
4a. Facility Name (If not institution, give DOCTORS HOSPITAL 5. Social Security Number 6. Se		. last birthday)	4b. City, Town, or LANH If Under 1 Year	Location of Death AM If Under 24 Hrs.	8. Date of Birth		Death CE GEORGE''S Birthplace (State or Foreign Country)
	XIM 2□F 66	Yrs.	Months Days	Hours Min.	JULY 26		Country) RKANSAS
10a. State 10b. County MD PRINCE G		ity, Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 □ No
10e. Street and Number 8645 SEASONS WAY			10f. Zip Code 20706			10g. Citizen of Wha	•
MD PRINCE G 10e. Street and Number 8645 SEASONS WAY 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grace) Elementary/Secondary (0-12)	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No A If Yes, Give Year or Dates:	rmv	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. BLACK
15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ang	16b. Kind of Busin	
17. Father's Name (First, Middle, Last) IDIE C. DAVIS				MARY	ROSEBURE		
19a. Informant's Name/Relationship (7 PERRY BROWN/COU	USIN	-					nte, Zip Code) NSAS 72110
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crei	osition (Name of matory or other place V CEMETER	e)	²⁰⁰⁶	20c. Location - Cit	y or Town, State I, ARKANSAS
21. Signature of Funds Service Licen	500		2. Name and Address 474 LANDO	. 0		CINS FUNE ER, MARYL	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	quence of):	lerotic	- Cen	diovers	scular	012esse
IF FEMALE:	23c. If yes, outcome of preging the little birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date o Month	•
Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.			ite to the cause of death? Probably 4 Unknown
dia	betes				24a. Was a autop perfor	rmed? prio dea	re autopsy findings available r to completion of cause of th? Yes 25 No
25. Was case referred to medical	Hospital:		- ac pos Cth	26. Place of Dea			
1 res 4 No	1 ☐ Inpatient 21 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur	y at		dence 6 Other ((Specify)
27. Manner of Death	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
23e Cartifliar 1 Cartifying Ph (Check only one) 2 Medical Exam	ywician. To the best of my kininer: On the basis of examinand manner stated.	nowledge, deal nation and/or in	h occurred at the tire vestigation, in my o	ne date and place pinion, death occur	and due to the c rred at the time, c	date and place, and	of ac ctated. I due to the cause(s)
29b. Signature and title of certifier			29c. Licens			29d. Date signed (A	
30. Name and address of person who o	V 57511a	in Stree	Print) T Su Te	351, La	lure/, (MO 2070	7
31. Date filed (Month, Day, Year) JUN 1 3 2006	32. Registrar's Sig	nature.	w				

State of Maniland / Department of Health and Mental Hygiene S. C. C.

	_	For State Registrar		State of Ma	irylario /	Ce	rtificate of	Death			Reg. No.	200	-	
Physic	an	Decedent's Nam		DASHIELL JR. assistance, pre-street aron murbow)										
/Medi	cal				. ,		4b. City, Town, o	or Location		UNE				40 4
Exami	ier						STEVENS	VILLE			OI	JEEN A	NNE'S	
- Funeral		5. Social Security		6. Sex 7. Age	(In yrs. last		If Under 1 Year	If Under	24 Hrs. 8.	Date of Bir (Month, Da				ate or Foreign
Director		217-10-8		1MM 2LIF	88	Yrs.			0	1/10/	1918			
and		Usual Residence of 10a, State	10b. County		10c. City, To	own or Lo	ocation						10d. Insid	de City Limits
Mary	tor	MD	OHEEN	ANNE † C	STEVE	NSVI	I.I.F						1 🗇	Yes 2₹ No
h the	Director	10e. Street and Nu		ANNE D	DILIVI	21013					10g. Citizen of What Country?			
th wit		412 LOVE	E POINT	RD.										
atior death with the Marylan or items 23a or 28a-f show iminer must be notified at	Funeral	11. Marital Status		Armed Forces?			Was Decedent of H If Yes, specify Cub	Hispanic Or an, Mexicai	igin? (Specif n, Puerto Ric	y Yes or No can, etc.))+			ın,
rs afte	by F		4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🙀 No	Specify:	•				JHT TE	
is in 15-0050 within 72 hours after death with the Maryland jiene. rihan "natural", or items 23a or 28a-f show the Medical Examiner must be notilised at		(600	15. Decedent	's Education		6a. Dece	dent's Usual Occup	pation	st of working		16b. Kir			
- 35	Completed	Elementary/Sec		T	+)	life.	DO NOT use retire	d)	st or working					
filed withir Hygiene. other then		11	(Fire baidate	(100)	J	RADIO	ADVERTI		or's Namo /F	Firet Middle			NG	
a d is d	Be										, maidell	Jumamer		
Tyle	7				1	19b. Maili	ng Address (Street				er, City or	Town, Stat	e, Zip Code)	
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Physician /Medical		disease or conditi	ion	a			tibrilla	twn					3	
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I HECOTGS, P.O. BOX The law requires that the death cer tite has been signed by the attendir page 2 should be detached for use	Physician/M			9LJ Unknown										
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DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,	Medical	(Check only		Exeminer: On the basis of	f examination									use(s)
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State of Maryland / Department of Health and Mental Hygiene * 🔠 🗓 🤚 1 - For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Rosezena Dean 0935 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4anFacility Name (If not institution, give street and number) Examiner Wiconico enional Medicas Center enusula If Under 1 If Under 24 8. Date of Birth Month, Day, Year 12/6/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛣 86 Yrs Maryland Director <u> 218–24–7258</u> Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir then "netural", or items 23a or 28e-f ehow tre Medical Examiner must be notified at 1X Yes 2 No Maryland Wicomico Salisbury Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exercises 200.2. 806 Register Street 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) . 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory 8 0 Folder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Slate Duck Callie Vaughn ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene D. Smith/daughter 31929 Dagsboro Rd., Parsonsburg, MD 21849 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Wicomico Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/06 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Park 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part / Enter the disease, or complications " at cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau'e on each line. Approximate Interval Between Onset and Death ceretto vascular Immediate Cause (Final **Physician** acci disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit ned by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 3 Probably 1 Tyes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an hes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death.
I Director: Af
d in by the fur 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of the 29c. License number 29d. Date signed (Month, Day, Year) HO059368 completed cause of death (Item 23a) (Type, Print) 30. Nai Ist. Salisbury MD 100 E. Carrell 1500 32. Registrar's Signature 31. Date filed (Month State Registrar

		1 - For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment	of Health and of Death	d Mental Hy	giene 2006 Reg. No.	20406
Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Year	3. Time of Death
/Medi Examir	cal	Muriel Edwards Da 4a. Facility Name (If not institution, give			4b. City, To	own, or Location of De	May 24	2006 4c. County of Dear	1:57 P
Funeral Director	ier	Holy Cross Hospit 5. Social Security Number 6. Security Number 10. Security Number 6. Security Number 10.	a1 7. Age (In yr	s. last birthday,	Si:	Lver Sprin	g	Montgon	
/land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
e Man	ctor	Maryland Montgom	ery Si	lver S					1 ☐ Yes 2 🕅 No
with the or 2	Dire	10e. Street and Number			10f. Zip C	20904		10g. Citizen of What Co	ountry?
is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itsm 27 is marked other than 'natural', or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	13608 Fairridge D 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decede If Yes, specif	nt of Hispanic Origin? y Cuban, Mexican, Pi	(Specify Yes or No uerto Rican, etc.)		e, etc.
natur	letec	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece (Give	dent's Usual	Occupation done during most of retired)	working	16b. Kind of Business	Industry
z withir d withir giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Typist	1811180)		Federal G	Sovernment
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n y la	2	William Edwards 19a. Informant's Name/Relationship (Ty	ne Print)	19h Maili	ing Address /		m Jones	er, City or Town, State, 2	Zin Code)
nd 2 s alth an 27 ts		Stephen Davis/Son			-			11e, MD 207	
of Health of Health or other tra		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ R	20b	. Place of Dispo cemetery, cre			Date	20c. Location - City or	
permit. Pages ' Department of P Important: if its eny injury or of		4 □ Donation 5 □ Other (Specify)	I					006 Brentw	
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Physician Ite be executed Asician and Examiner Permisit and Permisit a	ical Examiner	23a. Part1. Enter the disease, or con plants, or heart failure. Lift only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, layers and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	spirator equence of): osis equence of): nemonia					Approximate Interval Between Onset and Death
Attending Physicien: The law requires that the death certificate be executed reach. releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic prec ⊒ Other (spec			23d. Date of del Month	ivery Day Year
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ar neco	Completed						1 ☐ Yes	prior to death? 2 No 1 □ Yes	itopsy findings available comptetion of cause of 2 No
VICION: 'sicion: 's certifica director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1X Inpatient 2	☐ ER/Outpatie	nt 3□ DOA	Other	Death (Check only on Home 5 Thesia	one) dence 6 □Other (Spe	cufu)
nding Phy ath. r: After this		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)			c. Injury at Work? 1 Yes 2 No		now injury occurred	ony)
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To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physical Check only one)	cause(s) and manner as date and place, and due	stated. to the cause(s)					
within i	Med	29b. Signature and title of certifier	29d. Date signed (Mont	h, Day, Year)					
		30. Name and address of person who co	empleted cause of geath (III	em 23a) (Type		052261		June 23,	2006
		Alan R. Segal, M	1517 Hugo (Cir, Si	lver S	oring, MD	20906		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 8 2006	2. Registrar's Sig	nature .	and a				

			1 - For State Registrar	State of N	Marylar	nd / Depa	artmei <i>rtifica</i>	nt of H	lealth a Death	and N		giene	UU 6	2043	
	Physici	ian	Decedent's Name (First, Middle			- · · · · · -					2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medi		EDWARD DANIEL								JUNE	q'	2006	4:45 A	VI.
	Examir	ner	4a. Facility Name (If not institution UNIVERSITY OF MAR	-		TER		TIMORI	Location of	of Death		Ac. Co	unty of Death		
	Funeral Director		5. Social Security Number 223–62–4121	6. Sex 7. A 1 A 2 F	Age (In yrs. 59	last birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 16	y, Year)	9. Birth Cou Mary	place (State or Forei ntry) 1and	gη
Vland	WOL IN		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limit	s
Mar	- 3	ctor	MD Anne	Arundel	We	st Rive	er							1 □ Yes 2	0
with th	Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Iteme 23s or 28s-f ehow any injury or other traumatic event, It's Medical Examinar must be notified at once.	I Director	10e. Street and Number 5337 Sudley Re	oad			10f. Zi	2077	8				of What Cou	ntry?	
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	Menta! Irked o	To Be	Edward L. Dan							a Ge		, Maiden Sur	name)		
rary 2 shou	and h		19a. Informant's Name/Relations								a/ Route Numbe			Code)	
1, 1, and ₹	fealth om 27 ther tr		Michelle Danie 20a. Method of Disposition	els (Wife)	20h (River,				
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To the Hospital or Attending Physician: The law requires that the death certificate	signed by the attending phy: d be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a	2 Feta	ıl death 3 □	Ectopic p						Date of delive	ery Day Year	_
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5 5	s efter al Dire ed in t	Certi	4 Homicide determine	building, e	tc. (Specif	y)		,			City or Tow	in, State)		r route reamber,	
• Hospi	within 24 hours efter death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical	29a. Certifier 1 Certifyin (On such only one)	g Physician: To the best Examiner. On the basis of and manner s	or examina	wiedge, death tion and/or inv	occurred	at the time, in my op	e, date and inion, death	place, a	and due to the d ad at the time, d	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)	
Toth	withir To th comp	Me	29b. Signature and title of certifier				290	. License	number		-	29d. Date sig	ned (Month, i	Day, Year)	
			· Cemie J	M.D.				P14	840		-	JUNE 9,	2004		
			30. Name and address of person CON NIE TENG 2					ez i	ID OIG	ra i				1000	
	Sta	te	31. Date filed (Month, Day, Year)	32. Sigist	rar's Signa	iture	P	, KO, P	11/ 11/	U					
	Registr	_	JUN 1	3 2006		S. A	MAN TO SERVE								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Mary Virginia Davidson June 14 2006 3:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 ☐ M 2X F Months Days 99 Sept.9, Director 226-07-2825 1909 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov the Medical Exeminer must be notified at 1 Yes 2 No Directo Charles Waldorf Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö itams 23a 20602 12857 Owens Drive United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be if timent of Health and Mental Heart: if Item 27 is marked out jury or other traumatic ever William Edward Curley ဥ Mabel Louise Raleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Vallandingham / Son 12857 Owens Drive, Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or QDCE. 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal Cem 6-19-2006 St. Mary's City, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signa Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ehydration **Physician** /Medical Due to (or as a consequence of): **Examiner** OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţō in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 Ø No 21000 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge death occurred at the line, date and place and due to the cause(s) and macrier as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057999 MD 6/16/06 30. Name an haddress of person who completed cause of death (Item 23a) (Type, Print) 11637 Terrace Drive Ste 103 Walday, MD 2063 MANISHA JARIWALA, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 9 2006

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 3:40 P. M Doretha Eason June 7, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Center Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 2,1938 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X**) F Director 238-64-8793 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits rai, or items 23a or 28a-f shov Examiner must be notified at Prince Georges Directo Maryland Temple Hills 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6526 Beachwood Drive 20748 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: **Black** Specify: 3 XWidowed 4 □ Divorced "naturai', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r then Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Homemaker Domestic othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental John Eason Dora Lassiter ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 i Joyce Denise Eason (Niece) 6526 Beachwood Drive; Temple Hills, Maryland 20748 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 12 20c. Location - City or Town, State ertment of h ortent: if its injury or of North 4 ☐ Donation 5 ☐ Other (Specify) **2006** Carver Park Cemetery Murfreesboro, Carolina 21. Signature of Puneral Service License 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. Deper mpor any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has lirector, page 2 s autopsy performed Division of Vital 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2 □ No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s effer dea. ••i Director: Afte 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō within 24 hours e To the Funereil completely filted pellil Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joseph D40324 JUNE 8, 2006 ss of person who completed cause of death (Item 23a) (Type, Print)

4 JOORIE, M.D. 7503 SURRATTS READ, CLINTON MARTLAWD 20731

State Registrar

JUN 1 4 2006

31. Date filed (Month, Day, Year)



			- negistrai	ate of Marylar	nd / Depa	artmen	t of He	alth and	d Mer	ntal Hygi	ene g. No.	2005	20	4
	Physici	an	Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Year	3. Time of 0	
Division of Vital Records, P.O. Box 68760, lor Attending Physician: The law requires that the death certificate be executed after death. In or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and the first this certificate has been signed by the attending physician and the properties of					. Ec					June	T	2006	9:15	_A ^M
Physician (Medical Examiner) Physician (Medical Examiner) Prince George Hospital Cente Funeral Director Prince George Hospital Cente Social Security Number G. Sex 7. Age (In yrs. last birth 224–36–9537 120 Maryland Prince George's 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryland Prince George 10c. City, Town Maryla					ntor			_	eath			inty of Death	oorao l	<u> </u>
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	ath w	rai										USA		
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S, D	quiras that in signed b uld ba deta		Part II. Dther significant conditions contribu	ting to death but not res	ulting in the u	nderlying c	ause given	in Part I.		23e. Did toba	/	ontribute to the	cause of dea	
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	he Hospital n 24 hours a he Funaral i piataly fillad	edical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	wledge, death	n occurred avestigation,	at the time, in my opin	date and pla ion, death or	ace, and o	due to the cau t the time, dat	ise(s) and e and plac	manner as sta	ted. he cause(s)	
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	(2)		30 Name and address of person who comple	ted cause of death (Item	1 23a) (Type,	Print)	/ >	Dir- 1	14	FUED	1. 1	110	20018	,
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2006	7. Registrar's Signa	iture	L)	J WI	YIE	-112	VEN	il r		0 700	<i>J</i>

			State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department / Departme	Mental Hy	giene Reg. No. 20	U6 2044,
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De	Day	Year 530 p M
	/Medic		Marion Madeline Engel	June		3 1
4	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County	of Death
	F		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th	9. Birthplace (State or Foreign
П	Funeral Director		213-05-7351 1 M 2 F 85 Yrs. Months Days Hours Min.	June 2	th 1 <i>y, Υθας)</i> 7 , 1920	Country) Maryland
	D .		Usual Residence of Decedent			
	arylar show	_	10a. State 10b. County 10c. City, Town or Location Harford Havre de Grace			10d. Inside City Limits 1 ☑Yes 2 ☐ No
	he M	ecto			10- 011	
	with the party	Funeral Director	10e. Street and Number 10f. Zip Code 21078		10g. Citizen of W	
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Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the feath say a marked other than "natural", or items 23a or 28a-1 show other traumatic event, I'm Medical Exam her must be notified at	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus			
	and 2 salth a n 27 is er tra		Deanna M. Campbell (Daughter) 1906 Hibbins Pl. Ha	vre de (Grace, M	D 21078
ore	of He of He if item		20a. Method of Disposition 1 Burial 2 Cremation 3X Removal from State	Date		City or Town, State
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Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum once.		21. Signature of Euneral Service Licensee Tarring—Cargo Fune Aberdeen, Maryland	21001	-3399	
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	/Medical Examiner		Due to for as a consequence of):			
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Ö	al or / after i Dire d in b	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or To	wn, State)	
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	within To th compl	Me	29b. Signature and title of certifier 29c. License number)	29d. Date signed	(Month, Day, Year)
•			XABO MO 06\$768		6/21/	100
	7		30. Name 1 address of person who completed cause of death (Item 23a) (Type, Print)		1 1	
	V		31. Date filed (Month, Day, Year) 32. Registrar's Signature	-		-
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2006 32. Registrar's Signature			

		1 - For Amend #5 State of Maryland / Per FH G872 10 / Per	Certificate of		Reg. N	o	3. Time of Death		
Physici /Medic Examin	cal	WARY EDWARDS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	M	lonth D	ay Year 1 2 0 1 c. County of Dea	062-10 A		
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Ba-f show	ector	Maryland Caroline Hend	wn or Location				10d. Inside City Limit		
penint raggs 1 and 2 strong being mining in rough and beautiming in may your Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Medical Evarth or invalite incitified at once.	Funeral Director	10e. Street and Number 25341 Hollingsworth Circle 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21640 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Y an, Mexican, Puerto Rican	U res or No-	SA 14. Race - Am Black, Whi	erican Indian,		
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Departm Importar any inju		21. Signature of Funeral Service Licensee Maph C Fleegle	Fleegle and PO Box 160	ess of Facility id Helfenbein Greensboro,	Funera Maryla	1 Home,	PA)		
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octor: After this certificate has been signed by the attending physician and sold the funeral director, page 2 should be detached for use as the burial-transit	ical Examiner	Sequentially list conditions, Tarry, leading to him solidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a donsequence consequence) c. Due to (or as a consequence consequence)	et et):	ravij			Gmonth		
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within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier R. R. D. C. M. 30. Name and address of person who completed cause of death (Item 23a RVPAL F. D.C.S.A.), 2 i.O.S. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	29c. Licens	opinion, death occurred at the se number	he time, date an	ate signed (Mont	h, Day, Year)		
		30. Name and address of person who completed cause of death (Item 23a							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Murset Rollins Forsythe

2006 20443

Maryland Charles Waldorf 1x Yet	e or yland City Limits 2 No
Social Security Number Social Security Num	yland City Limits 2 No
Director 215-28-5844 X X	yland City Limits 2 No
Director Company Manual Manual Manu	yland City Limits 2 No
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Maryland Charles Waldorf 10/. Zp Code 2004 Wingate Court #7 2004 Wingate Court #7 2005 11/. Marital Status 1 Never Married 2 Married 1 New Forces? 1 Never Married 1 Never Married 2 Name Forces? 1 Never Married 1 Never Married 2 Name Forces? 1 Never Married 2 Name Forces? 1 Never Married 2 Name Forces? 1 Never Married 3 Never Married 2 Name Forces? 1 Never Married 3 Never Married 1 Never Married 2 Name Forces? 1 Never Married 3 Never Married 1 Never Married 2 Name Forces? 1 Never Married 3 Never Married 2 Name Forces? 1 Never Married 3 Never Married 2 Name Forces? 1 Never Married 3 Never Married 3 Never Married 2 Name Forces? 1 Never Married 3 Never Married 4 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 6 Never Married 1 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 6 Never Married 1 Never Married 6 Never Married 1 Never Married 1 Never Married 6 Never Married 1 Never Married 1 N	2 No
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24a Was an autopsy performed? The policy of the policy of	mber, City
Composition of the control of the co	
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. We decided Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. We decided Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. 29c. License number 29d. Date signed (Month, Day, Yea	-)
O.C.M.E. June 10, 2006	,
30. Name and attdress of person who completed cause of death (Item 23a)	
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31 Date filed (Month, Day, Year) 2. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Up on Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Yeer 2006 June 10, 9:20 A M Nancy Lee Franks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's 12403 Stirrup Lane If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 M 2 XF 216-58-5835 Director 52 01/03/1954 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel; or items 23a or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12403 Stirrup Lane Bowie USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler LMIC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gordon Bradley Melvin Frances C. Lombardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Franks/ Son 12403 Stirrup Lane Bowie, MD 20715 20a. Method of Disposition
142 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 06/14/2006 Suitland, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence of) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signed page 2 should be Yes 2□No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death
1 XNatural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Clerine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 1 4 2006

WD

32 Registrar's Signature

06-04414 Lily Filbey

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Book on,	man these	District State of Sta	

		1- For State Registrar	ertificate of D	eath			Reg No.	201	JO 204	
Physicia	n/	Decedent's Name (First, Middle,Last)				2. Date of De Month		ear	3. Time of Death	
Medical Examin		Lily May Filbey				June 24,	2006		0220 hrs	
	ı	4a. Facility Name (if not institution, give street and number) University of Maryland Shock Trauma		city, Town, or Baltimore	Location of	Death	4c. County	of Death		
Funeral		5. Social Security Number 6. Sex 7, Age (In yrs.		If Under 1 Yea			irth(MM/DD/YYY	(Y) 9. Birth	nplace (State or Maryland	
Director		219-22-9639 1 M 2 K F 78	Yrs.	Months Day:	s Hours	Min. May 2	2, 1928	Cou	ntry)	
>-	-	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location						10d. Inside City Limits	
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Maryland 28a-f show d at once.	흱	Maryland Cecil 10e. Street and Number		t Depo	SIL		10g. Citizen of V			
th the Maryland 23a or 28a-f sho notified at once	Director	137 Dr. Jack Road		o בוף סיים	21904		-	U.S.A	,	
s 23a e noti		11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was D	ecedent of His	spanic Origi	n? (Specify Yes or N			an Indian, 8lack,	
death wi	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes,	specify Cuban	n, Mexican,		ite, etc.			
after o	호 노	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Ye	es 2 X No	specify:	Specify	:	White		
nours	g [15. Decedent's Education (Specify only highest grade completed)		Jsual Occupation (Give kind of work done of working life. DO NOT use retired)						
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Secreta	arv	Greenwoods Garage Baltimore, Maryland				
5-003 Thed within Hygiene. Jother th	탉	Twelve Years 17. Father's Name (First, Middle, Last)				Name (First, Middle	1		Maryland	
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ID 21215 2 should be file 1 and Mental H 27 is marked of matic event, II		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ac	ddress (Stree		per or Rural Route Nu				
re, MD 21; I and 2 should b Health and Men Fitem 27 is mar'	L	Scott Filbey (son)). Box 181, I				
imore, MD 2121; Pages 1 and 2 should be fil ment of Health and Mental Is lant: If item 27 is marked or other traumatic event,	1	20a. Method of Disposition 20b. 1 Burial 2 Cremation 3 Removal from State	 Place of Disposition crematory or other 		metery,	Date	20c Location	ı - City or T	own, State	
imo Page ment c			sbury Cem	-		06/27/06	Port D	eposi	t, Maryland	
Baltimore, permit. Pages 1 at Department of Het Important: If ite injury or other tr		21 Signature of Funeral Service Clounsee		e and Address A. Pat		n & Son Fu	neral H	ome.	P.A.	
Physician	- 1	23a. Part I. Enter the disease, or complications that caused the deat							Approximate Interval	
/Medical		failure. List only one cause on each line.	Between Onset and Death							
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Box 68 le death certite the attendin	£L	1 Yes 2 No 9 V Unknown 9 Unknown				,				
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ord aw red nas bee	ple					auto			mpletion of cause of	
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	lg	2 Accident Investigation 28e Place of Injury - At		actory, office b	ouilding, etc	28f. Location	(Street and Numl	ber or Rura	al Route Number, City	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	Suicide 6 Could not be determined (Specify) Hospita	1			Havre de	State) 501 Sc Grace, M	juth Un	nion Ave	
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To the Hos within 24 ho To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation			urred at the time, date				
	Σ	29b Signature and title of certifier	. ^	29c Licens			29d Date sign		h, Day, Year)	
		laror Hulla	V	O.C.I	IVI. ⊏.		June 24, 2	2006		
		30. Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner	m 23a) 111 Penn Str	eet Baltim	ore MD	21201				
2 Sta	ate				, 1710					
Regist	rar	31 Date filed (Month, Day, Year) 7 2006 32. Revistrar's Signa	ature & Appa	W .						

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1.	. Decedent's Name (First, Midd	die, Last)			_			2. Date of De	ath		3. Time of Death
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5	ST. VINCENT	6. Sex		yrs. last birthday) If Unde	r 1 Year	EMMITSE If Under 24 Hrs.			ERICK 9 Birtholas	ce (State or Foreign
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17	7. Father's Name (First, Middle,	, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Suma	me)	
		JOS	EPH H. 1	FRANK			M	ARY AGNI	ES ATHM	AN	
1	9a. Informant's Name/Relation	nship (Type, Prin	t)	19b. Mail	ing Address	s (Street	t and Number or Ru	iral Route Numb	er, City or Town	n, State, Zip Co	ode)
	SISTER CAMILLA	A HARANT	SUPERIO	OR 333	3 S. S	SETO	N AVE., E	MMITSBU	RG, MD.	21727	
2	0a. Method of Disposition			b. Place of Disp cemetery, cre	osition (Na	me of other pla	ice)	Date	20c. Location	- City or Towr	, State
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			ST. JOS			!	3/06	EMMITSE	BURG. M	D. 21727
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ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene / 1116 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dolores Ann Fuller June 23, 2006 6:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Allegany 9. Birthplace (State or Foreign Country) 934 Weires Avenue LaVale If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 19, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F 1940 212-38-6181 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or liems 23a or 28a-f show other treumstic event, the Madical Examiner must be notified at 10a. State 1.□Yes 2□No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 934 Weires Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Be Completed by White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Ie marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Senior Cardiac Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Joseph Grabenstein Nonnita Frances Cosgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19830 Copperhead Rd, SW; Rawlings, MD Annette Flesher--daughter 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park | 06/27/2006 Cumberland, MD 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Furieral/Service Licensee 108 Virginia Ave: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List brily one cause on each line. mmediate Cause (Final d Physician Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificete be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ctor: After this certificate the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours efter death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 THomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00033280 June 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta, M.D.; 625 Kent Avenue; Cumberland, MD 31. Date filed (Month, Day, Year) 32. Projetrar's Signature State JUN 2 9 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 6 State Registrar items 10e, 15, 16a&b, 19b per Gaftificate of Death wichd/6-20-06 dls Amended 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Month 4a. Pacility Name (If not institution, give street and number Farrington Lune 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Keninsula Regional Medical Center Salisbury Wiconics f Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other then "natural", or Itams 23a or 28a-1 show other traumatic event, It a Medical Exarch an inual ke incitified at MD W. conico 1 Yes 2 No Directo 10e. Street and Number 424 10g. Citizen of What Country? 10f. Zip Code 21865 U.S.A 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces:

1 Ayes 2 No
If Yes, Give
Year or Dates: ALMY 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: ۵ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Education 11th grale Clover High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and Mental F. Arthur Farrinator FarringLow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Cap. Cula Pages 1 and 2 ment of Health a ant: if Item 27 is Tyask 2 1865

Date 2 c. Location - City or Town, State Loneda Fallington-WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donarion 5 ☐ Other (Specify) injury or Grace U.M. Ch Conete 6/17/06 White Hum no 21. Signature of uneral Service Licensee 22. Name and Address of Licility 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** INFARCTION /Medical Due to (or as a consequence of): Examiner ASCVO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and the burial-transit FAILURE Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificete 1 ☐ Yes 2 ☐ No of Vital 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ₹ No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending efter death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) 0063199. 30. Name and oddre is of person who completed cause of death (Item 23a) (Type, Print) VOHRA CASTERN SHOLE DR SUITEB, SALISBURY MD, 21804 OGESM 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 14 South. Registrar

DHMH 17 Rev 1/2001

220

FARRINGTON

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		Registrar	1 43		Certificate of			Reg. No.		3. Time of Death
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edic		Glenn Herbert 4a. Facility Name (If not institution, c			4b. City, Town, o	y Location of De			ounty of Death	
ımin	er	Carroll Hospita				stminst		10: 00	Carro	
ral				(In yrs. last birtho	day) If Under 1 Year	If Under 24 H	irs. 8. Date of Bir	th Vacel		place (State or Foreig intry)
r		507-14-3365 Usual Residence of Decedent	1⊠M 2□F	85 Yrs	s. Months Days	Hours M	lin. May 21,	1921	Nei	braska
	tor	10a. State 10b. County Maryland Car	roll	10c. City, Town o	stminster					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Funeral Director	10e. Street and Number 2610 Wilton Ct.			10f. Zip Code 211	.58		10g. Citizer	n of What Cou USA	intry?
	era	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of H If Yes, specify Cub		(Specify Yes or No	o- 14.	Race - Ameri	
	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ₹ Yes 2 □ No If Yes, Give Year or Dates:	wii	1 ☐ Yes 2 🛣 No		ierto Hican, etc.)		Black, White, pecify: Wh:	ite
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	Be	17. Father's Name (First, Middle, La					Name (First, Middle	, Maiden Su	ımame)	
	ဥ	David Earl Frar		10h A	Mailing Address (Street		Matejka	er City or Ti	own State 7i	in Code)
	l j	Dawn Franck Wat		ter 19	08 Rainbow	Dr., S	ilver Spr	ing, l	MD 2090	05
OUCE.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery,	Disposition (Name of crematory or other pla		/16/2006		tion·City or T stead,	
		21. Signature of Juneral Service Lie	_					-		
_		Mayle W	war		Pritts F 412 Wash					21157
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Registrar DHMH 17 Rev 1/2001

State

32 Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 6 2006

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	Physici	an	Decedent's Name (Fire										2. Date of D Month	Day	Year	3. Time of Death
	/Medic		Sharon	Lynn	Fri								June	21	2006	7:30A M
	Examin	er	4a. Facility Name (If not . 32 Frederic	_	e street and	l number)			4b. City,		Location of			4c. Co	Carro	1
			5. Social Security Number		Sex	7. Age	(In vrs. la	ast birthday) If Under		If Under		8. Date of B	irth	O Diebe	lace (State or Foreign
N. sejihat	Funeral Director		212-62-427		1 □ M 2 🛣		53	Yrs.	Months	Days	Hours	Min.	Dec.	14,195	2 Mar	y land
	D		Usual Residence of Dec						1				1			
	arylar	٦		o. County	1.1		10c. City	, Town or L		r					1	0d. Inside City Limits 1 X es 2 No
	he M	Director	Maryland	Carro) I						/town			10a Citian	of What Cour	
	with t		10e. Street and Number 32 Frede	arick '	S+				10f. Zip		21787				.S.A.	itry?
	leath	Funeral	11. Marital Status	SI ICK .	12. Was [Decedent E	Ever in U.S	S. 13.	Was Deced			gin? (Sp	ecify Yes or N Rican, etc.)		Race - Americ	an Indian,
0	ritter or Item	Fun	1 Never Married	2 Married	Armed	d Forces? es 2.[★N	lo					i, Puerto	Rican, etc.)		Black, White,	etc.
ğ	rel', c	1 by	3 ☐ Widowed 4 🔀	Divorced	Year o	, Give or Dates:			1 Yes	21 X No	Specify:			Sp	ecify: Whi	te
21215-003	filed within 72 hours after death with the Maryland Hygiene. After than "naturel", or Items 23a or 28a-f show ant, the Macical Examiner must be notified a	Completed		Decedent's E		e <i>d</i>)		(Giv	edent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. Kind	of Business/In	dustry
2	within ane. than	E G	Elementary/Secondary	y (0-12)	Colleg	ge (1-4or 5	+)		fice r					pet	roleum	service
7 7	Hygie Hygie Sther		17. Father's Name (First	, Middle, Las	t)						<u> </u>	er's Name	e (First, Middl	1 .		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "raturel", or Items 23a or 28a-f show aumatic event, the Marsical Exertities relative notified at	To Be	Raymond	Haine	S						G	lady	s Smit	h		
ary	should have		19a. Informant's Name/I	Relationship	(Type, Print)			19b. Mail	ing Address	(Street a	and Numbe	or Run	ai Route Num	ber, City or To	own, State, Zip	Code)
	and 2 Baith n 27 I		James D. K		ing/fi	ance	-		Frede				neytow			
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke ery injury or other traumatic 2008.		20a. Method of Dispositi 1 ■ Burial 2 □ Cre		☐Removal fr	om State	20b. PI	ace of Disp emetery, cre	osition (Nar matory or o	ne of ther place			Date		ion - City or To	
Ë	t. Partmen		4 Donation 5 D		-	, ,	Win	ters					2006			lsor, MD
Ba	permit. Departm Importa eny inju		21. Signatur of Funeral	ine (). XVa	ingl	en	3	10 Ch	urch	St.	Ne		sor, M	D 21776	5
			23a. Part1. Enter the dis shock, or heart fail	sease, or con lure. List only	plications the one cause of	nat dadsed on each lin	the death	. Do not en	ter the mod	le of dying	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fina disease or condition resulting in death)		_ a	Tono	zul	Cano	av							quontes
	/Medical Examiner		rosaling in doaling	•	Due	to (or as	onsequ	ience of):	,						America de Adamas	
	े देश	er	Sequentially list condition any, leading to immed	ons,	b. — Dua	to (or as a	a consequ	erica ut):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	* *	С.											
o`	an an rial-tr		resulting in death) Last			to (or as a	a consequ	ence of):								
8760,	Attending Physician: The law requires that the death certificate be executed releath. releath. sctor: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit.	licai			d											
ی ×	ertifica ding ph	Physician/Med	IF FEMALE:		220 Hugo	outcome	of present	2011								
Вох	attenc for us	ian	23b. Was decedent pred in the past 12 mon	ths?		ve birth regnant at	2 Fetal	death 3	□Ectopic pr					230	. Date of delive Month	Day Year
o.	the de y the iched	ysic	1 ☐ Yes 2 No 9 ☐ Unknown			nknown	umo or de	1	011161 (3)	ocny)						
o.	es that the death certific igned by the attending p be detached for use as	by Pt	Part II. Other significant	t conditions	contributing t	to death bu	ut not resu	Iting in the	underlying c	ause give	en in Part I.		23e. Did	tobacco use	contribute to th	ne cause of death?
g	w require been sig should by												1 🗆	Yes 2 n	lo 3 Prob	ably 4 □Unknown
Records,	e law re has be je 2 sho	Completed											24a. Wa	s an 2	4b. Were auto	psy findings available
œ —	ysician: The is certificate hadirector, page	Ę											per	formed? 22 No	death?	2 No
/ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to examiner?	o medical						1		of Deatl	Check only	one		
of	Physical this call direct	2	1 ☐ Yes 2 ☐ No 27. Manner of Death			Inpatie		ER/Outpatie			4 🗀 140				Other (Specif	()
O	ding h. After funer	tion		Pending investigated	(/	Month, Day	Year)	Injury	M	28c. Injury Work	vai √? Yes 2 🔲 I		28d. Describe	now injury o	ccurred	
Division of Vital	r Attending Phy er death. rector: After this i by the funeral d	fica	3 ☐ Suicide 6	Could not I	28e. P	lace of Inju	ıry - At ho	me, farm, s					28f. Location	(Street and N	umber or Rura	l Route Number,
	9 # 5 E	Certification:	4 Homicide		b	uilding, etc	с. (Бреспу)					City or 10	own, State)		
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check Gnly 2)	Certifying P Medical Exa	miner. On tr	the best one basis of nanner sta	examinat	wiedge, dea ion and/or ii	th occurred rvestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the	e cause(s) an	d manner as s ace, and due to	ated. the cause(s)
	within To the Comple	Me	29b. Signature and title	of certifier			. ^		290	c. License	number			29d. Date s	ignerd (Month),	Day, Year)
					~	- h	1			DO	05	80 3	35	6	12110	6
1	7		30. Name and address of	of person who	completed of	cause of de	eath (Item	23a) (Type	Print)	102	179	Je	nnifer	Canci	no	
	Sta		31. Date filed (Month, D			2. Registra	_	ure			, ,					
100	Registr	ar	JUI	1222	006	AMARIA	Red A	J. B.	make							

			4	eartment of Health and Me ertificate of Death		ene 006	2045
			Decedent's Name (First, Middle, Last)	- 2	2. Date of Death		3. Time of Death
	Physici		George Purnell Frederick,	Jr.	June 2	Day Year 1, 2006	8:00 a.m.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Julie 2	4c. County of Deat	
	_Admin		Calvert Memorial Hospital	Prince Frederick		Calver	-
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year ff Under 24 Hrs. 8	B. Date of Birth	9. Birt	hplace (State or Foreign
н	Director		216-40-5413 12XM 2□F 63 Yrs.	Months Days Hours Min.	(Month, Day, Y Iov • 6 •		vland
	<u> </u>		Usual Residence of Decedent				/
	show	L	10a. State 10b. County 10c. City, Town or L	ocation .			10d. Inside City Limits
	89-f	cto	Maryland St. Mary's	Loveville			1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	23e		40450 Fredericks Lane	20656		nited Stat	tes
	tems rems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No- can, etc.)	14. Race - Ame Black, White	
36	or I	by Fi	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 🛣 No ff Yes, Give	1 ☐ Yes 2 🛣 No Specify:			Lack
8	hour tural	d b	3 Widowed 4 Divorced Year or Dates:				
21215-0036	"na"	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	7	6b. Kind of Business/	Industry
12	withi ene. than	ш	Elementary/Secondary (0-12) College (1-4or 5+)	Laborer		0	
g 5	filled Hygi ther ant,		17. Father's Name (First, Middle, Last)	18. Mother's Name (/	First Middle Ma	Constru	iction
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23e or 28e-f show minportant: If them 27 is marked other than "natural", or litems 23e or 28e-f show any injury or other traumatic event, the Maryland Examiliar matter mailied at once.	To Be	George Purnell Frederick, Sr.			n Dickerso	
<u></u>	shoul mari	F		ing Address (Street and Number or Rural F			
S	od 2 ith ar 27 is						<i></i>
ē,	Hea Hea tern other		20a. Method of Disposition 20b. Place of Dispo	Box 63, Loveville, osition (Name of Dat	mary Lar	c. Location - City or	Town, State
altimore,	ages ant of it: If i		A Burial 2 Cremation 3 Hemoval from State	ematory or other place)			
Ē	artme ortan injur	- 7	Ducted in	eart Cem. 6-24-	2006 BU	ishwood, M	laryland
Ba	permi Depa Impo any ir		V:10 C C:407 V01206	2. Name and Address of Facility Brin	sileld F	uneral Ho	ome, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	2955 Hollywood Road attemption of the mode of dying, such as cardiac or r			20650-0279 Approximate
		8	shock, or heart failure. List only one cause on each line.	0 + = /:	,	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	Unl Failed	-		
	Examiner		To Control Annual Control Cont	Hund Failers			
		e.	Sequentially list conditions, if any, leading to first underlying the Cue to (or as a consequence of):	14011 1-21(62)			
	uted d ansit	듄	cause, Enter Underlying Cause (Disease or injury that initiated events	11/h/			
o T	exec in an	Examiner	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical	d				
89	ifficat g phy as th	ed					
Вох	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	De		23d. Date of delin	very
Ω.	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
o.	that the de led by the a detached f	hys	9 ☐ Unknown 9 ☐ Unknown				
ď.	es tha igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Ë	w require been sig should b	ed t	Myperthosis, Demishin		1 🗌 Yes	2 🗆 No 3 🗀 Pro	obably 4 Onknown
Division of Vital Records,	aw requ	Completed			24a. Was an	24b. Were au	opsy findings available
æ	The tay cate has page 2	mo			autopsy performed	d? prior to co	ompletion of cause of
a		O	25. Was case referred to medical	26. Place of Death C		No 1 □ Yes	22.140
<u>></u>	ysici is cer direc	OB	examiner? 1 Yes 2 No Hospital: 1 Department 2 ER/Outpatier	Other		e 6 Other (Spec	(fu)
0	Attending Physician: r death. sctor: After this certific. by the funeral director.	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury		d. Describe how i		
<u>Ö</u>	tendir feath. tor: Af the fur	atlc	2 Accident investigation	M 1 Yes 2 No			
<u> </u>	l or Atten after deatl Director: In by the	iji l	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)	reet, factory, office 28f	Location (Stree City or Town, S	at and Number or Rui	ral Route Number,
	tal or A rs after al Direct ed in by	Certification;			Ony or 10000, 0	idioj	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only C	h occurred at the time, date and place, and	d due to the cause	e(s) and manner as	stated.
	the Ho nin 24 the Fu npletel	ledi	and manner stated.				
	To the within: To the comple	Σ	29b. Signature and little of centifier	29c. License number	29d.	Date signed (Month,	, Day, Year)
)	11		10000	Duo 6/947		10/06	
	~		30. Name and address of person who completed cause of death (Item 23a) (Type,	•			
	D1 -		Manoj Mathur, M.D., 100 Hospital Roa	ad, Prince Frederick	k, Maryl	and 20671	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 4.			
	Registr	211	JUN 2 3 2006 June 1				

			1 - For State Registrar	State of M	aryland		artment rtificate					Reg. No	211114	204	52
F	Physici	an	1. Decedent's Name (First, Middle,	·	. 1						2. Date of De Month	Da		3. Time of D	
	/Medic Examir		Richard C 4a. Facility Name (If not institution,	harles give street and number)	Fow1	er	4b. City,	Town, or	Location of	of Death	June	22,	2006 c. County of Deatl	6:38 a	·m."
		pit.	41135 Paw Paw	Hollow				Le	onard	town				larv's	
	Funeral		,	5. Sex 7. Ag	ge (In yrs. la	st birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bir (Month, Da	ıy, Year	9. Birth	nplace (State or I	
	Director		188-30-1316 Usual Residence of Decedent		68	TIS.				N	Nov. 1	, 19	37 Penr	sylvani	a
	nyiano how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City	Limits
	Ba-f s	Directo		Mary's					rdtow	'n				1 Tyes 2	! □ X No
	a or 2	Dire	10e. Street and Number				10f. Zip				,	10g. Ci	tizen of What Co	untry?	
	death ma 23	Funeral	41135 Paw Paw	12. Was Decedent		. 13.1	Was Deced		650 spanic Ori	gin? (Spec	rfv Yes or No)-	United S		
ဖွ	or ite		1 ☐ Never Married 2 🔀 Marrie				f Yes, speci 1 ☐ Yes 2			i, Puerto R	rfy Yes or No ican, etc.)		Black, White	, etc.	
21215-0036	72 hours after death with the Maryland naturel', or itema 23a or 28a-1 show dical Examirar rout be indiffed at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:					Specify:				Specify: W	hite	
5	in 72 in at	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Deced (Give	dent's Usual kind of worl DO NOT use	l Occupa k done d e retired	ition <i>Juring m</i> osi I	t of working	9	16b. k	(ind of Business/I	ndustry	
212	with piene r than	omo	Elementary/Secondary (0-12)	College (1-4or:	5+)	Engir		o rotilog,				TT	S. Gover	nmant	
פ	al Hyg	Be	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name (First, Middle,			micric	
yla	Ment Ment Marke Marke Marke	2	Richard W. Fow								et McH				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-1 show any figury or other traumatic event, the Macical Examinational Remitted at ODGs.		19a. Informant's Name/Relationshi Barbara A. Fow										or Town, State, Z		
5	s 1 an f Heal ftem 2 other		20a. Method of Disposition	rer / wire	20b. Pla	ce of Dispo netery, cren	Paw sition (Nam	e of	нотт	OW, L			n, Mary 1		00
E	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Lady)	-27 - 2	006		ndel, Pe		
Baltimore,	apartir porta iy inju		21. Signature of Funeral Service Li	censee	Sum							Fui	neral Ho	me. P.A.	IIa
_	40 E 9 9		Kyle S. Simon		M01206	5 22	955 H	lo11y	wood	Road	, Leon	ardt	own, MD		
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused by one cause on each li	_	Do not ent		of dying	, such as	cardiac or	respiratory ar	rrest,	and the second	Approximate Interval Betwee Onset and Dea	
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):						_			
	ted sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	а сопявона	nne of):									
8760,	cate be executed physicien and the burial-transit	ai Exar	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):									
Ó	g phys as the	edicai		d.											
P.O. Box	The law requires that the death certific te has been signed by the attending pl page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe						23d. Date of deliv Month	ery Day Yea	ır
a. O.	res that igned b	by Pr	Part II. Other significant condition	s contributing to death b	ut not resulti	ing in the un	iderlying cai	use give	n in Part I.		23e. Did to	obacco u	use contribute to t	he cause of deal	th?
ğ	w require been sig should b										1 🗆 Y	es 2	□No 3□Pro	bably 4 Unk	.nown
Division of Vital Records,		Completed									24a. Was autop perfor 1 ☐ Yes	sy	24b. Were auto prior to co death? 1 \(\subseteq Yes	ppsy findings ava empletion of caus	ulable se of
V Ita	stcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		=		7		of Death	Check only o	/ _			
ō	this al di	2	1 ☐ Yes 2 No 27. Manager of Death	Hospital: 1 Inpatie		Outpatient			4 🗀 1901		d. Describe h		6 ☐ Other (Special	(y)	
0	th. : After s tuner	ţ	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Date)	y Year)	Injury	м 20	c. Injury Work?	ai es 2 □ N		u. Describe n	ow injur	y occurred		
NSIN	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not		ury - At hom	e, farm, stre	et, factory,	office		28	f. Location (S	treet an	d Number or Run	al Route Number	
ā	ital or irs afte ral Dir led in	Cer									City or Tow				1
	To the Hospital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the	edical	29a. Certifying (Check only one) (Check only one)	Physicien: To the best of aminer: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at estigation, i	t the time n my opi	e, date and nion, deatl	d place, and h occurred	d due to the o at the time, o	ause(s) date and	and manner as s place, and due to	tated. o the cause(s)	
	Son Twith	Σ	29b. Signature and title of certifier	,al			29c.	License	number 170	60			e signed (Month,		
F	6		20 Name and address of the same	n completed access (anth /lt	20) (T		> '	7/0	00		6.	2210	0	
	8/	1	30. Name and address of person wt Avani D. Shah,				,	rt.	Leona	rdto	m. MD	206	50		
	Star Registra		31 Date filed (Month, Day, Year)		ar's Signatur	0			neona	ILULUV	vii, PID	200	JU		
	negletti.		JUN 4	M COULD	STATE OF THE PARTY										

		1 - For State Registrar		arylanu /		artment of H tificate of I			Reg. N	6 UI	96	20450
Physicia /Medic		Decedent's Name (First, Middle, WYLODENE	Last)	GOODE	N			2. Date of I Month JUNE	eath Da 13		Year 006	3. Time of Death 4:00 A M
Examin Funeral Director		4a. Facility Name (If not institution, 2106 EAST MARS 5. Social Security Number 410–78–8719	HALL PLACE 5. Sex 7. Age	e (In yrs. last b	irthday) Yrs.	4b. City, Town, or LANDOV If Under 1 Year Months Days		s. 8. Date of E	irth Day, Year		E GE	ORGE 'S ace (State or Foreigr TY) ESSEE
פ	or	Usual Residence of Decedent 10a. State 10b. County MD PRINCE	GEORGE'S	10c. City, Tov	m or Lo			DELLE	10 1	.547		od. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow	ai Director	10e. Street and Number 2106 EAST MARS				10f. Zip Code 20785			1	itizen of W		
irs after deal I', or Items	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? d 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba Yes 28 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	lo-		- America r, White, e	
within 72 horenesses than "natura	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give i life. [ent's Usual Occupa kind of work done of DO NOT use retired, TRITER	uring most of we	orking	16b. F	Cind of Bus		ustry
2 should be filed and Mental Hygis is marked other raumatic event, I	To Be C	17. Father's Name (First, Middle, L CLARENCE DRE	ast) W INGRAM				LILLIA		AVES	Sumame	3)	
s 1 and 2 should of Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationshi DONNIE GO 20a. Method of Disposition	p (Type, Print) ODEN/HUSBANI) 2	106	g Address (Street a EAST MARS	SHALL PI		DOVE	R, MA	RYLA	ND 20785
permit. Pages Depertment of the Important: If Its Important: If It		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	ecify)		INCO	sition (Name of latory or other place LN CEMET) Name and Addres	ERY 6/2	20/2006	BR		, OD,M	ARYLAND
Depe Impo		23a. Part1. Enter the disease, or o shock, or heart failure. List b	-hal	the death. Do	7	474 LANDO	OVER ROA	AD LANDO	VER,		AND	
Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ENDOM	ETRAIL a consequence	CANC							Interval Between Onset and Death
flicate be executed physicien and is the burial-transit	edical Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence			· · · · · · · · · · · · · · · · · · ·					
	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 12 4 □ Pregnant at 19 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mont		y Day Year
equires thet en signed brould be deta	by P	Part II. Other significant condition	s contributing to death bu	it not resulting i	n the un	derlying cause give	n in Part I.					cause of death?
n: The law r ficate has be or, page 2 sh	e Completed	25 W-				_		1□ Yes	ormed? 2% No	de	or to comp ath?	sy findings available pletion of cause of [X] No
or Attending Physicien: The lay affer death. Director: After this certificate has in by the funeral director, page 2.	108	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending investiga	28a. Date of Injury (Month, Day)		utpatient Time of Injury	3 DOA Other	4 □ Nursing I	ath Check only Home 5½ Res 28d. Describe	idence			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification;	3 Suicide 6 Could no determin	building, etc	. (Specify)				City or To	wn, State)		Poute Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1⊠ Certifying 2 Medical Example. 29b. Signature and title of certifier.	Physician: To the best o aminer: On the basis of and manner stat	examination ar	e, death id/or inve	estigation, in my opi	nion, death occi	e, and due to the urred at the time	date and	and mann place, an	d due to ti	he cause(s)
(3)		30. Name and address of person w	W completed cause of de	ath (Item 23a)	(Type P		3253			UNE		2006
State Registra		JONATHAN COSIN 31. Date filed (Month, Day, Year) JUN 1 4 200	M.D. 110		ST N	I.W. # 5B	33 WASHI	INGTON, D	C 20	010		

			1 - For State Registrar		Marylar		artmen rtificat					Reg. No.	2006	2	01	:54	
	Physici	an	1. Decedent's Name (First, Middle,		-						2. Date of De Month 06	ath Day 12	Year 06		me of		
1	/Medic Examin		David Colum 4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death	-00		County of Dea			<u> </u>	-
			Washington Adv	entist Ho	spital				Park			N	lontgon	nery			
	Funeral		5. Social Security Number 250-62-6860	. Sex 7 1 M 2 □ F		last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. Bi	rthplace (Sountry)	tate or	r Foreign	
Н	Director		Usual Residence of Decedent		66						06 2	1 39		SC			-
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Ins		•	
	Ba-f e	Funeral Director		Georges	C	apitol								1	Yes	2 🗌 No	_
	with t	Dir	10e. Street and Number				10f. Zip	207	4.2				en of What C .ted St	-			
	death	nera	4515 Heath Str	12. Was Deced	ent Ever in U	I.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Am	erican Indi	an,		-
9	or its	Fur	1 ☐ Never Married 2 ☑ Married	Armed Force 1			ir Yes, spec 1 □ Yes :		n, Mexican Specify:	i, Puerto i	Hican, etc.)		Black, Whi	ite, etc.			
8	hours lural',	d by	3 Widowed 4 Divorced	Year or Date	es:								B1	ack			_
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Madical Enaminar must be notified at	Completed	15. Decedent's (Specify only highest	grade completed)	(a. F.)	(Give	dent's Usua kind of wor DO NOT us	rk done d	lurina mosi	t of worki	ng	16b. Kin	d of Business	s/Industry			
212	d with giene er tha	E O	Elementary/Secondary (0-12)	College (1-4	OI 5+)	Coad	hman					Amt	rak -	Trans	por	tati	Lc
nd	be filed tai Hygid d other event, t	Be	17. Father's Name (First, Middle, La	est)							(First, Middle,	Maiden S	Sumame)		•		
Maryland	should be and Mental e marked o	ဥ	David Glover 19a. Informant's Name/Relationship	(Type Print)		10h Mailie	an Addross	(Stroot o			Ravene		Tours State	Tin Code l			
Z	and 2 s ealth an n 27 ie i		Jeanne E. Glover				•				itol He	. ,		, , , ,			
Je,	of Heal		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. f	Place of Dispo cemetery, crei					ate		ation - City o		ıte		-
Ē	Pages ment of I ant: if Its ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		orrea	dy For	k Mis	s. B	apt 0				son, N				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentai Hygiene. Important: if Item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow amportant: or other traumatic event, the Medical Enablinar must be notified at 000e.		21. Signature of Funeral Service Lie	tuckl	ana	/					ickland , Camp					, P.	A
	Physician //Medical Examiner the private and private in the priva	Examiner	23a. Part1. Enter the disease, for or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	as a consecutive as a c	can juence of): Me juence of):	rer	1			alle los			Appro Intervi Onset	ximate a! Betw and D	reen	
P.O. Box 68760,	I the death certific by the attending p eched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ⊡Feta ntattime of c	ıl déath 3□	Ectopic pro					2:	3d. Date of de Month	olivery Day	Y	ear	
	w requires that been signed to should be det	by	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	on in Part I.		23e. Did to		e contribute t No 3□P	o the caus			
Vital Records,	ysicien: The law requisions to certificete hes been director, page 2 should	Completed						-			24a. Was autop perfo		24b. Were a prior to death?	completion	ofca	variable use of	
VII K	Attending Physicien: The death. ector: After this certificete by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o						
	Physic this stal di	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		8c. Injury Work	4 LI NU	- 1	ne 5 Resid			ecify)			-
ion	nding ath. r: Afte e fund	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury	М		:? /es 2 ☐ f	No		. ,					
Division of		Certification:	3 Suicide 6 Could no 4 Homicide determine	289. Place of	Injury - At h	ome, farm, str	eet, factory	, office		2	18f. Location (S City or Tow	Street and vn. State)	Number or R	ural Route	Numb	997.	-
	To the Hospital or within 24 hours effe to the Funeral Dircompletely filled in	Medical	29a. Certifier Certifying (Check only one)	Physician: To the barriner: On the bas	is of examina	wledge, death ition and/or inv	occurred avestigation.	at the tim in my op	e, date and inion, deat	d place, a	nd due to the o	cause(s) a date and p	nd manner as place, and due	s stated. e to the ca	129(S)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	6			29c	. License	number	D1		29d. Date	signed (Moni	th, Day, Ye	gr)		-
)			1 tren	NP	n	The state of the s		58	40	14	1	13	Ju	1	01	5	
2	(5)		Name and address of person wh	o completed cause	of death (Iter	n 23a) (Type,	Print)	11	°, 11	. 7)	KE /	Rani	. II =	MI	2	0851	
	Sta	te.	31. Date filed (Month, Pay Year)	7. 2. 1 Z	istrar's Signa	ture	ROC	KV	ME		KE /	IOCK	VILLE,	ild.			1
	Registr		31. Date filed (Month, Pay 6 20[16 Alexander	J. 15	1000	20										

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1-For State RegistrarAmend #10a-f Per Inf G85 Pertificate of Appath Rea No 2. Date of Death Physician/ June 7, 2006 2120 hrs Medical Examiner LUTHER WESTON GREGORY 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Queen Anne's Chester 2900 Cox Neck Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Foreign Director Country) TX 1 **X** M 09/06/1917 2 F Yrs 88 449-16-7609 Usual Residence of Decedent 10b. CountyCollier 10d. Inside City Limits 10a State 10c. City, Town or Location Yes 2 X No FLNaples 111)-QUEEN ANNE'S CHESTER hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e Street and Number 34108 7071 Verde Way 21619 USA 2900 COX NECK RD. 23я 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Funeral 11 Marital Status Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 1 X Yes è If Yes, Give Year 1939 1 Yes 2 No specify: 3 XWidowed 4 Divorced Specify: WHITE à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 l is marked other than atic event, the Medical 5+ DESIGN ENGINEER ELECTRICAL MANUFACTURE and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED BELL ELISHA GREGORY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN LANDIN / DAUGHTER 310 OAK LANE, RICHMOND, VA 23226 1 and 2 s Health a 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) Pages 1 X Burial 2 Cremation 3 Removal from State PETERS CEMETERY 6/10/2006 QUEENSTOWN, MD Donation 5 Other Specify:
Signature of Ineral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK RD., CHESTER, MD 21619 HOME, P.A. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** on each line Between Onset and /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Physician/ Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown cate has been signed by the atte page 2 should be detached for i Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes No 28a Date of Injury FOUND: Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Deceased shot self Certification **FOUND** Natural Yes 2 V No Pending Director: the Jun 7, 2006 2054 hrs Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 2900 Cox Neck Road, Chester, Md determined Funeral (Specify) Single Family Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner state 29c. License number 29d. Date signed (Month, Day, Year) 29b. Stanature and title of o June 8, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. Assistant/Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

		•	For Stata Registrar	State of M	arylar				lealth a Death	ind Me	ntal Hy	giene Reg. No.	00	5 20	456
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, L. C. Sa. L.) Sa. L. Sacility Name (If not institution, gi	Nd	G	Ran	+		Location of		Date of De Month	Day	Ye	6 21	of Death
	Funeral Director				ge (In yrs.	last birthday) 58	ff Unde Months	r 1 Year	If Under 2 Hours	Min.	Date of Bir (Month, Da	rth ay, Year)		Birthplace (Sta Country) irginia	
	the Maryland 28a-f ehow	Director	10a. State 10b. County Maryland Howard 10e. Street and Number			ty, Town or Lo		p Code				10g Citiz	en of What	1 🗆 Y	City Limits
	should be tied within 72 hours atter death with the Maryland and Mental Hygiene. They is the William Sa or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Madical Exemptor Land by Incities at	Funerai	9502 Ridgeview D 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	?		21	046 edent of Hi ecity Cuba	ispanic Orig n, Mexican, Specify:	gin? (Specif , Puerto Rid	ty Yes or No can, etc.)	USA o- 1	4. Race - A Black, V	merican Indian /hite, etc.	,
21215-0036	a within 72 hours jiene. r than "natural", ina Madical Ext	Completed by	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	Year or Dates: Education rade completed) College (1-4or	5+)	16a. Dece (Give life.	dent's Usu kind of wi DO NOT i	ial Occupa ork done d use retired	during most)		entati	16b. Kin	d of Busine	Black pss/Industry Dmmunic	ations
Maryland 21	should be filed vind Mental Hygie is marked other inmatic event, in	To Be C	17. Father's Name (First, Middle, Las Earl F. Thomas, 19a. Informant's Name/Relationship	Sr.					18. Mother Berni	r's Name (/	First, Middle Smit	h Maiden S	Sumame)	e, Zip Code)	
ο ·	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic events.		Terri M. Grant/d 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State		9502 Place of Disponentery, crein	sition (Na matory or	me of other plac	e)	Dat		20c. Loc		or Town, State	
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service Lice 22. Signature of Funeral Service Lice 23. Part 1. Enter the disease, or core	Leatte	Mo	- G∂ 01251ве	Sing a	Home y L.	screma Heckr	ition	Servi	Clar		Box 784	
	hysician /Medical Examiner	8 10	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on each I	ine. Teast	- C	ance		siTh		teis tasi	3	n	Interval	Between nd Death
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P.O. Box 68	I ne law requires that the death certilicate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic p					23	3d. Date of Month	delivery Day	Year
ords, P	w fequires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death b	out not res	sulting in the u	nderlying	cause give	en in Part I.		10	Yes 2	No 3	e to the cause of	□Unknown
ital Rec		Be Completed	25. Was case referred to medical examiner?						26. Place	of Death (24a. Was autoperfo	psy ormed? 2 No	24b. Were prior death		gs available if cause of
	utending Physical distributions of the funeral distribution of the funeral distributions of the funeral	Certification: To I	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	be Gen Blace of In	ury ay Year) jury - At h		M	28c. Injury Work 1 🗆 `	4 Nur	280	5 Resid. Describe Location (City or To	how injury	occurred	pecify) Rural Route N	umber,
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7-	with To	W	29b. Signature and title of certifier CU W 30. Name and address of person who	m)	death (Ito	n 23a) (Tuno	Print)	c. License	0053	700	ì	Jun	G 15,	2006	
y)	کر Sta	ite		w LA 32. degist	4300	Gall	ant	F	ux l	cini	STE	#	210	Bowle	mo 26713

		or State Registrar
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222-26-4953

BARKSARA GERMAN

20457

			1 - State Registrar				Cen	ificate	e of E	Death			Reg. No).			
			1. Decedent's Name (First, Mic	idle, Last)		-						2. Date of De	eath Da		Year	3. Time of	Death
	Physici /Medi		Barbara Lee	German								JUNE		200		2300	5 M
-at	Examir		4a. Facility Name (If not institu				1	4b. City, 1	Town, or	Location o	of Death			. County	of Death		
			Peninsula 1	Legior	ral Me	dica	Center		5/2	lish	ure		ì	WI	Coni	co	
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under	24 Hgs.	8. Date of Bir (Month, Da	rth Vear			place (State or	<i>r Foreig</i> n
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	P ,		Usual Residence of Decedent 10a. State 10b. Cour			10- 0'-	¥										
	aryta hov	_	10a. State 10b. Cour	ty		TOC. City	, Town or Loc	ation							1	10d. Inside Cit 1 X Yes	•
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	Vith t	Director	10e. Street and Number					10f. Zip					10g. Cit	izen of V	What Cour	itry?	
	ath w	a	204 East Kin					199						SA			
	er de	Funeral (11. Marital Status		Was Decedent E Armed Forces?		s. 13. W	as Deced Yes, spec	ent of His fy Cuban	spanic Origin, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	>-		æ - Americ ck, White,	can Indian, etc.	
36	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-1 show dical Examinar must be notitled at	by F	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes — 2 ☐ No If Yes, Give Year or Dates:	0	1	☐Yes 2	No K	Specify:				Specify	y: \[\bar{\bar{\bar{\bar{\bar{\bar{\bar{	White	
Maryland 21215-0036	hours ture!',	ed		ent's Education			16a. Decede	nt's Usua	Occupat	tion			16b K	ind of Bu	usiness/Inc	dustry	
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a	should be nd Mental marked o matic eve	To B	Milford Hear	ne						Eve	1yn	Hill					
<u>a</u>	2 shou and M is mar		19a. Informant's Name/Relation	nship (Type,	Print)		19b. Mailing	Address	(Street ar			I Route Numb	er, City o	or Town,	State, Zip	Code)	
	5 4 2 5		Tammy German	(Daugh	ter)		204 E	ast K	ing	Stre	et S	eaford,	, De	. 19	973		
Baltimore,	s 1 a f Hea fitem othe		20a. Method of Disposition			20b. Pla	ace of Disposi metery, crema	tion (Nam	e of	1	D	ate	20c. Lo	ocation -	City or To	wn, State	
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			23a. Part1. Enter the disease.	or complication	ons that caused t	he death.	Do not enter	the mode	of dying,	, such as	cardiac o	r respiratory a	rrest,	7730		Approximate	
	Physician	0.00	shock, or heart failure. L	st only one ca	ause on each line		5.0	24.0	1	140		MA				Interval Betw Onset and D	reen reath
2	/Medical		disease or condition resulting in death)	a	Due to (or as a	consequ		Duit	14	50	47	MA				4 da	45
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	rtifica ng ph as th	Jed	15 5511115	-		_								17			
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. l	If yes, outcome o	f pregnan		ctopic pre	onancy					23d. Dat	te of delive	iry	
	dea de att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	'	4□Pregnant at ti 9□ Unknown			Other (spe						Mor	ath	Day Y	ear
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Division of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	al						26. Place	of Death	Check only o	-				
>	SOF	2	1 ☐ Yes 2 ₺ No	Hosp	ital: 1 🗡 Inpatien	2 □ E	R/Outpatient	3 DO	Other	4 🗆 Nu	rsing Hon	ne 5 ☐ Resid	dence	6 □Othe	ar (Specify	1)	
0	ding Ph. h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pen		Ba. Date of Injury (Month, Day	Year)	28b. Time of Injury	28	c. Injury a Work?	at	2	8d. Describe	how injur	y occurr	ed		
<u>S</u>	Attending r death. Atter oy the funer	ati	2 ☐ Accident inve	stigation				М		es 2 N	No						
Ξ̈́	r Att	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 2	8e. Place of Injur building, etc.	y - At hor (Specify)	ne, farm, stree	it, factory,	office		2	8f. Location (5 City or Tox	Street an	d Numbe	er or Rura	Route Numb	Θ <i>Γ</i> ,
۵	rel D	S															
	To the Hospital or Attendi within 24 hours effer death. 7 to the Funerel Director: A 3completely filled in by the fu	Medical	Check only 2 Madic	BI EXAMINAL:	n: To the best of On the basis of e	ixamınatı	ledge, death on and/or inve	stigation,	t the time	, date and	d place, a	and due to the	cause(s)	and mar	nner as st	ated.	
	the the the the the the the the the the	Jed	one,		and manner state	ed.											
	15 To 00	-	29b. Signature and title of certi	7\				29c.	License	number	_		29d. Dat	e signed	I (Month, L	Day, Year)	
	7/13		1 Julier 2	1/	1				117	143	4		6/	401	6		
(Ta		30. Name and address of person	n who comple	eted cause of dea	ath (tem	23a) (Type, Pr	int)	A	143	CA		7	MI) .	0- 1	
	U		Julios D.	ZAN	5 560	hly	JENY (C	u yr	, Al	02	XIL	1384	y,	M	1 7	21801	
	Sta		31. Date filed (Month, Day, Yea	5 2006	32. Registrar	s Signatu	ire						1				
-	Registr		(0011 1	0 4000	[Constant	4	7. Co	matter 1									
DH	MH 17 Rev 1/20	JO1					A										

			1 - For State Registrar	State of I	Marylan		artmen rtificati			nd M		giene	0.5	20458
ı	Physici	an	Decedent's Name (First, Middle Herman	Joseph	G	rabens	tein		Jr.		2. Date of De Month Jun 21.	Day	Year	3. Time of Death
1	/Medio Examir		4a. Facility Name (If not institution 201 Sunset Driv	give street and number		nabens	4b. City,	Town, or	Location of	Death	Juli 21		y of Death	<u>1:05 am</u> ⁴
	Funeral Director		5. Social Security Number 215-12-2326 Usuel Residence of Decedent	6. Sex 7. 1 [X]M 2 ☐ F	Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Apr 22		_	place (State or Foreign atry)
	e Maryland	ctor	10a. State 10b. County	gany	10c. Cit	y, Town or Lo Cum	berlar	nd					1	0d. Inside City Limits 1 ☐ Xes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 201 Sunset Driv	/e			10f. Zip		21502			10g. Citizen of	What Cour	ntry?
9600	i 72 hours after death with the Maryland "netural", or Iteme 23e or 28e-f ehow idigal Examination notified at	þ	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give Year or Date	s? No		Was Deced If Yes, spec 1 Pes 2		spanic Origin, Mexican, I	n? (Spe Puerto	ecify Yes or No Rican, etc.)	Speci	VVIIIL	etc.
Baltimore, Maryland 21215-0036	within ene. then	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-40	or 5+)	16a. Dece (Give life. Jewell		rk done d se retired,	luring most o	of worki	ng	Jewelry		
yland	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, I Herman J. Gi	abenstein					Mary	y (C	Greene)	Maiden Suma Graben	stein	
, Mar	12 sho h and 7 ie m traum		19a. Informant's Name/Relations of Irene Grabensto	ip (Type, Print) Bin wife					nd Number (IVC	or Rura	Cumber Cumber	er, City or Town Derland	, State, Zip	VD 21502
imore	Pages 1 and ment of Heelt ant: If Item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1 0	Place of Dispo emetery, crei Peter Pa	natory or or	thar place	y) Y		oate 6/24/2006	20c. Location		
Balt	permit. Page Department of Important: If any injury or pnce.		21. Signature of Furleral Service t	icensee Aa	spel	0- 22					me, P.A. ; Cumbei	land, MD	21502	
	Physician /Medical Examiner	Examiner	23a. Par1. Enter the disease, or, shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to amendiate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cerebr Due to (or: b. Lue to (or:	ı line.	ular A			, such as ca	ardiac o	r respiratory ai	rest,	1	Approximate Interval Between Onset and Death MONTH
Q	that the death certificate be executed the by the attending physicien and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcom	2 Fetal	death 3]Ectopic pre] Other (spe					1	ate of delive	rry Day Year
	sign d be	þ	Part II. Other significant condition Diabetes Melli		but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	1		e cause of death? ably 4 Unknown
l Reco	The ete h page	Completed	Hypertension						-		24a. Was autop perfo	sy med?	prior to con death?	psy findings available inpletion of cause of
Division of Vital Records,	ing Physician: After this certific uneral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Vatural 5 Pending 2 Accident investig			ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nursi	ing Hon	Check only o	/ N _		()
Divisi	or Al fter c Direc in by	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 28e. Place of	Injury - At ho etc. (Specif)	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Ton	Street and Numi n, State)	ber or Rural	l Route Number,
	To the Hospital or At within 24 hours efter of To the Funerel Direct completely filled in by	edical	29a. Certifier	Physician: To the be xaminer: On the basis and manner	of examinal	wledge, death tion and/or in	occurred a restigation,	at the time in my op	e, date and p inion, death	place, a	and due to the o	cause(s) and made and place,	anner as sta and due to	ated. * the cause(s)
		W	29b. Signature and title of certifier 30. Name and address of person of	en completed uses	death (Item	1 23a) (Tuno		License D3	number 35135			29d. Date signe	d (Month, E	Day, Year)
	Sta Registr		Thomas Chapp 31. Date filed (Month, Day, Year)	ell M.D.	strar's Signa	912 S	•		Cumb	oerla	and MD	21502		

ORIGINAL

			1 - For Stete Registrer	State of M	aryland		artment of			lental Hy	giene Reg. No	7 UHB	20	459
			Decedent's Name (First, Middle, Last	t)						2. Date of De	ath	-	3. Time	of Death
	Physici /Medio		RICHARD BERN	IARD	GRAV	ES				JUNE	12 ^{Da}	2006	4:5	5 A ^M
}	Examin		4a. Facility Name (If not institution, give				4b. City, Town,	or Location	of Death			. County of Deat		
			6001 Muncaster M					ville				Montgome		
	Funeral Director		5/8 42 9320	9x 7. Ag ☑ M 2□ F	72 (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da March	y, Year,	9. Birti Co 934 Wash	nplace (State untry) ningto:	or Foreign
	Mc m		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside (City Limits
	Marylen -f ehow lied at	ţō	MD. MONTGON	1ERY		GAIT	HERSBURG							s 2 □ No
	r 28a	rec	10e. Street and Number		1	·	10f. Zip Code				10g. Ci	tizen of What Co	untry?	
	h will	ai D	102 FAIRGROVE TER	RRACE			2087	7			UNI	TED STAT	ΓES	
36	should be filled within 72 hours after death with the Maryland Adental Hyglene. Imarked other then "naturel", or itema 23e or 28e-f ehow imarked other then "naturel", or itema 25e or 28e-f ehow imarked other than Madigal Examina man De nutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 XYes 2 I If Yes, Give Year or Dates:	No No	1	Was Decedent of f Yes, specify Cub	oan, Mexica	an, Puerto	cify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify: Wh		
Ş	2 hou	pel	15. Decedent's Ed	ucation	vor ean	16a. Deced	lent's Usual Occu	pation			16b. K	ind of Business/I	ndustry	
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	54)	(Give	kind of work done OO NOT use retire	duringmo	st of worki	ng			,	
7	giene The	E OC	12	0	34)	MANA	AGER				В	USINESS	MACHI	NES
g	m - 0 =	Be (17. Father's Name (First, Middle, Last)							(First, Middle	, Maider	Sumame)		
<u>yla</u>	should bind Ment	To	PETER MILHOUSE	GRAVES				R0	BERTA	. В	AILE	Υ		
Maryland 21215-0036	2 shot and in mile m	6 9	19a. Informant's Name/Relationship (7									or Town, State, Z		
	l and lealth im 27 her tr	1	JANET L. GRAVES,	MILE	20h Bla			L IER				RG, MD.		
0	Pages 1 nent of H int: if its		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cen	netery, cren	sition (Name of natory or other pla	ice)		ate		ocation - City or 1		
Baltimore,	rtmen rtant:		4 □ Donation 5 □ Other (Specify		GAT		HEAVEN	1	6/15			VER SPRI	NG, MI).
Ba	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If Item 27 is marked eny injury or other treumatic as once.		21. Signature of Funeral Service Licen Mariel H-	Barker			vùRìEL^dH ≥.O. BOX					E MD. 208	882	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause one cause on each li	d the death. ine.	Do not ente	er the mode of dy	ing, such as	s cardiac o	r respiratory a	rrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	a. END STA	GE CO	RONAR	Y ARTERY	DISE	ASE				Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as										
		<u>_</u>	Sequentially list conditions,	b. Due to (or as	1 00 00 mm	* * * * * * * * * * * * * * * * * * *								
	ted nsit	Examiner	if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce or).								
	al-tran	xar	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):						-		 -
8760	cate be executed physicien and the burial-transit	dicai E												
687	ficate g phy:	edic		a										
.O. Box	law requires that the death certific as been signed by the attending p . 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnance Other (specify)	у				23d. Date of delik Month	-	Year
<u> </u>	that the de led by the a detached f		Part II. Other significant conditions co	ntributing to death b	ut not resulti	ing in the un	derlying cause or	ven in Part	1	23e Did t	nbacco i	use contribute to	the cause of	death?
Records,	w requires that been signed should be de	ted by					acity and cause gr	vorisit uit			/es 2	_		Unknown
	0 - 0	Completed								24a. Was autor perfo		death?	opsy findings ompletion of a	available cause of
Vital	sician: The certificete rector, pag	Be	25. Was case referred to medical examiner?					26. Plac	e of Death	Check only			20.10	
	Physician: r this certific ral director,	٥	1 ☐ Yes 2 ☑ No	Hospital: 1 🗌 Inpatie	ent 2 🗆 EF	R/Outpatient	3□ DOA Ot	her: 4 □ N	ursing Hon	ne 5 ☐ Resid	ience	6.KOther (Speci	ty)HOSP	CE
000	ling Afte		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 □		8d. Describe I	now injur	y occurred		
Division of	5 # = c	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At hom c. (Specify)	e, farm, stre	et, factory, office		2	8f. Location (S City or Tov	Street an vn, State	d Number or Rui	al Route Nun	iber,
	e Hospital 24 hours e Funerei E letely filled i	edical C	29a. Certifier (Check only one) 1 Certifying Ph	rsicien: To the best iner: On the basis o	f examination	edge, death n and/or inv	occurred at the ti estigation, in my	me, date as opinion, dea	nd place, a ath occurre	nd due to the	cause(s)	and manner as : place, and due i	stated. o the cause(:	s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	a.eu.		29c. Licens	se number			29d. Dat	e signed (Month,	Day Year	
		0	KIN				D356					E 12, 20		
1	140	ł	30. Name and address of person who of	ompleted cause of a	leath /Item 2	3a) /Tunn /					UUN	L 12, 20		
			JOSEPH KAPLAN. M.				MILL ROA	חמ ח	CKNII	IE MD	2	0855		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	9	W a	, KU	CVAIL	LE, MU				
	Registr		JUN 14 2	.006	ar's Signatur	Ap	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Physician Jack Gonzales June 11, 1415 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SNOW HILL NURSING & REHABILITATION SNOW HILL WORCESTER 8. Date of Birth (Month, Day, Year) 9/17/1923 Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1**X**□M 2□F Months 82 085-18-0345 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Evaluiner must be notified at M Yes 2 No Director Maryland Berlin Worcester 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 21811 25 Fort Sumter South USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12☐ Yes 2 ☐ No If Yes, Give Year or Dates: Army 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specifywhite þ 3 Widowed 4 Trivorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, I've Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Head Start Program of Elementary/Secondary (0-12) and Mental Hygiene, is marked other than College (1-4or 5+) Head of Inspection Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Gonzales Blanche Cohen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Heelth an ent: If item 27 is s 222 Wintergull Lane, Annapolis, MD 21409 Patrick Gonzales/son other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō 6/13/06 permit. Page Department importent: If any injury or Salisbury, MD ' 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STO MACH **Physician** OF CARCINOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9☐ Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 1 Yes 2 100 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? certificate 1 Yes 2 Tho 1□ Yes 2□Mo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a 11 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 12/2006 a M. D D0062172

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

1604

MARKET ST

POCOMOKE CITY MD

21851 -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R

JUN 1 4 2006

SHARAD

31. Date filed (Month, Day, Year)

SATYAL, MD

32. Registrar's Signature

		1	For State Registrar	State of Maryla	nd / Department of Heal Certificate of Dea		/giene 006	20461
7	Physicia /Medic	an al	1. Decedent's Name (First, Middle, La	Henry	Gears	2. Date of D Month	Day 2006	3. Time of Death
	Examin Funeral Director	er S.A	221-14-5009	Hospital Ca		Inder 24 Hrs. 8. Date of 8 (Month, 5 of 1703)	4c. County of Death Action 19 inth lay, Year) 1928	ace (State or Foreign y) MD
pland	Wor.	-	Usuaf Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Location		10	d. Inside City Limits
A Mar	8e-fe	ector		ANNE'S	CHESTERTOWN		10g. Citizen of What Count	1 ☐ Yes 2√ No
with	3a or 2	I Dir	10e. Street and Number 217 CENTRAL DRI	VE	21620)	USA	. y :
5-0036	penint. Tages Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f ehow any injury or other treumatic event, the Madical Examiner must be rutified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Amed Forces? 1 24 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Me	ic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	14. Race - America Bfack, White, e Specify: WHI	tc.
15-0	natur	leted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b. Kind of Business/Indi	ustry
21215-0036	the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	FOREMAN		FOOD PRODUCT	ION
73 E	ind Mental Hyg	To Be C	17. Father's Name (First, Middle, Las JAMES THOMAS GE			Mother's Name (First, Middl MARGARET DA	ISY MORRIS	
	n 27 is main and in 27 is main		19a. Informant's Name/Relationship LELIA EVELYN GE	ARS/WIFE	19b. Mailing Address (Street and N	CHESTERTOWN,	MD 21620	
more	nt of He	3	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	Place of Disposition (Name of cemetery, crematory or other place) HESTER CEMETERY	Date 06/14/2006	CHESTERTOWN,	
Baltimore,	Departme Importent any injury		4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice	y)	22 Name and Address of	Facility	NEWNAM FUNER TOWN, MD 21620	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List ont	polications that caused the de y one cause on each fine.	ath. Do not enter the mode of dying, su		arrest,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CHRDIOP Due to (or as a cons		nest		Oliset and Death
	xaminer		Sequentially list conditions	b. Kefestas	tiz Squarusus	all cancin	onen Right	
3	asit S	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of): Earl	all Canesu to Lefthing	+ Splean	
50,	hysicien and the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):			
68760	g physic		7117-2-2-X	d				
ecords, P.O. Box 68760,	ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 Ectopic pregnancy		23d. Date of deliver Month	y Day Year
Q	signed by	by Ph	Part ff. Dther significant conditions	contributing to death but not r	esulting in the underlying cause given in	Part I. 23e. Did	tobacco use contribute to the	cause of death?
ords	been sig	sted t					T	bly 4 □Unknown
Œ ŝ	le has bage 2 sl	Completed					opsy prior to comformed? death?	sy findings available pletion of cause of
of Vital		Be	25. Was case referred to medical examiner?	Ho en ital:	Other	Place of Death (Check only	one)	
of	ung rnys h. After this o funeral dir	n: To	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 Infinpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at		sidence 6 Other (Specify) how injury occurred)
Division	r death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	on	M 1 ☐ Yes		(6)	
= 3	after d after d Direct d in by	Certification:	4 Homicide determine	28e. Place of fnjury - Al building, etc. (Spe	home, farm, street, factory, office cufy)		(Street and Number or Rural own, State)	Houte Number,
-	within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my kerminer: On the basis of examinar stated.	mowledge, death occurred at the time, dination and/or investigation, in my opinio	ate and place, and due to the n, death occurred at the time	e cause(s) and manner as sta a, date and place, and due to	
7					00-1:	mber	29d. Date signed (Month, E	ited. the cause(s)
,	within To the	Me	29b. Signature and title of certifier	0 0 11	29c. License nu			the cause(s) Pay, Year)
	within To the comple	Me	De aust	o complete cause of death (I				the cause(s) Pay, Year)
(t) 1	gratic	M	30. Name and address objects on what Folian C. Anna.	BACTR. M.D	tem 23a) (Type, Print) ZZ3 /fr gh Shut, U			the cause(s) Pay, Year)
6)	Sta Regist	₩ ate	30. Name and address of person wh	32. Registrar's Sig	tem 23a) (Type, Print) ZZ3 /fr gh Shut, U		6/12/06 , Ned 2162	the cause(s) Pay, Year)

State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician June 20 2006 10:00 p Kathryn M. Gilds /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ctr Carroll Lutheran Village Health Care Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 15 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Director 95 212-03-4020 1910 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ir then "naturel", or items 23a or 28e-f ehow the Medical Examinar count be notified at MD Carroll Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 rient of Health and Mental Hygiene. 21158 USA 250 St. Luke Cir. #609 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) ie marked other then Elementary/Secondary (0-12) Bank Teller Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harriet Babylon မ Levi David Maus

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 Port Republic, MD 20676 Joyce Wolber Daughter 3630 Pine Tree Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò permit. Page Department Important: if eny injury o 6/24/06 Meadow Branch Cemetery Westminster, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Covonan Physician Arten. neaso /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 2 1 No 1 Yes r: After this certification of funeral director, 25. Was case referred to medical examiner? Assited Loving 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manney of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00050763 30. Name and address of person who completed cause of death (Item (1) pp. Print) WESTMINSTERCHE 686-C POOLE PD MENDOZ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month Day WILLIAM B. GEHRING **Physician** 7:59P M JUNE 14 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 16748 WHITE STORE RD. MONTGOMERY BOYDS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Yrs 81 SEPT 14 218-16-0581 Director 1924 MI Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County od other than "natural", or itama 23a or 28a-f show event, its Medical Examiner must be notified at 1 Yes 2 No MONTGOMERY BOYDS MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16748 WHITE STORE RD. 20841 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No 1943 – IFYes, Give 1945 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CABINET MAKER and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any injury or other traumatic event once: Be RAYMOND WILLIAM GEHRING DOROTHY CLARK ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BETTY GEHRING / SPOUSE 16748 WHITE STORE RD., BOYDS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriaf 2 Cremation 3 Removal from State FREDERICK CREMATORY 6/16/06 FREDERICK, MD 4 Donation 5 Other (Specify) Funeral Service Licen 21. Signature RD., BARNESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DVQ5 CUI Physician Peroti /Medical Due to (or as a consequence of) Examiner Tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physicien Physician/Medical attending physic I for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 2 No 1 🗌 Yes certificate 1 Yes : After this certification 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🖺 Homicide within 24 hours a
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completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier fatucia 30) Name and address of person who completed cause of death (Item 23a) 10mg Ko 31. Date filed (Month, State 2006 Registrar

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permit. Pages Department of Important: If i eny Injury or once.	ļ	1100	104				Adan	ns Fu	neral	Home	e PA				
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42.1		30. Name and address of person who con	npleted cause of death (Item	¹ 23a) (Type,	Print)					,					
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Glady G. Gross

		•	1 - For Stata Registrar	State of Ma	ryland	•		t of He		ind Me	ental H	/giene Reg. No.		6	20465			
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	/Medic Examin									Location of Death 4c. County of Death								
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Т	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. las	st birthday)	If Unde	r 1 Year	If Under :		8. Date of B	irth	9	. Birthp	lace (State or Foreign try)			
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	D.		Usual Residence of Decedent					<u> </u>								_		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Louise F. Harris 11,2006 Lune 4:16R /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton P. G. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 5 ept. 8, 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F 231-42-5482 Director Va. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28e-f ehow The Medical Examiner oust be notified at Md. P. G. Clinton 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8307 Schultz Rd. 20735 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 ☑ No Specify Be Completed by 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hampton General other then Elementary/Secondary (0-12) College (1-4or 5+) Hospital permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Importent: If item 27 is marked other th any injury or other treumatic event, Use once. Surgical Technician 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ferrell Sallie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Alexander-Daughter 8307 Schultz Rd. Chinton, Cd. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Co. Line Church Cem 6-16-2006Halifax, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads St, N. E. 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOTENSION **Physician** 1 Day /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK 2Days Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 □Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperthyroidism 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Arteriosclerotic Vascular Disease page 2 certificate has 2∐No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To ty⊡Inpatient 2□ER/Outpatient 3□ DOA 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 12 Matural 5 Pending Injury death. 1 Tes 2 No 2 Accident investigation Director: 3 T Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the ...
within 24 hours ...
To the Funerel D' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Chack only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #104 Lanham Md. 20706 Rodney L. Ellis 9811 MD Greenbelt 31. Date filed (Month, Day, Year) 32. Registrar's S State JUN 1 3 2006 Registrar

			For State Registrar	State o		nd / Depa		t of H	ealth a		ental Hyg	jiene	-	201	167	
	in Sand		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death												of Death	
·	Physici /Medic		EDWIN DANIEL HE	DGES							Month 06	16	2006	12:43	3 A M	
	Examin		4a. Facility Name (If not institution		n <i>ber)</i>		4b. City,	Town, or	Location of	Death		ıth				
			33064 SHAVOX ROAD PARSONSBURG									WICOMICO				
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bir	thplace (State ountry)	or Foreign	
	Director		214-34-5506	1□XM 2□ F	69	Yrs.	Wienans	Days	110013	141111.	05-26-1	937		RYLAND		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside (City Limite	
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ğ	ours a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1962 1 ☐ Yes 2 No Spec										Specify: WHITE			
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Iteme 23a or 28e-f ehow ont, I'm Medical Exacutational Legicutified at	Completed	15. Deceden	it's Education st grade completed)		16a. Deced	tent's Usua	1 Occupa	tion uring most	of working	10	16b. Kii	nd of Business	/Industry		
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Maryland	be fi	Be	17. Father's Name (First, Middle,	ŕ							(First, Middle, I	Maiden	Sumame)			
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ā	12 st h and 7 le n traun		19a. Informant's Name/Relations								l Route Number	-				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, I'm Medical Evanting Indet traumatic event. I'm Medical Evanting Indet traumatic event.		TRUDI HEDGES -	SPOUSE	20h. F	3306 Place of Dispo	4 SHA	VOX	ROAD,	TAR	SONSBUR		cation - City or			
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Ba	Depa Impo Impo eny i		21. Signature of bulletin Service	Licensee /	Ocho	7	Name and	Addres:	A TAX OF	BOU	NDS FUN	ERAI	HOME,	INC.		
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Î	30.4		23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Authorized Leuken; c. Due to (or as a consequence of):											etween		
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ô	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							2	23d. Date of delivery Month Day Year					
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<u> </u>	or Attend after death Director:	1110	3 Suicide 6 Could i	ined 286 Place	of Injury - At he	ome, farm, stre	et, factory,	office		2	8f. Location (Str	eet and	Number or Ru	ıral Route Num	nber,	
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	Hospital 24 hours 27 Funerel I Tely filled	edical	29a. Certifier 1—Certifyin	g Physicien: To the Examiner: On the ba	best of my kno	wledge, death	occurred a	t the time	e, date and	place, a	nd due to the ca	use(s)	and manner as	stated.	- 1	
	To the Hospital within 24 hours a To the Funerel Completely filled	Med	one) 29b. Signature and title of certifier	and marin	er stated.										*/	
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225	M3m	1	20 Name and address of the	unho normalate d and		-		150	0040		ت	101	e /6,	2006	•	
-	102		30. Name address of pers					1 9	1	5.	1.360		Mis			
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	Registr	-	JUN 1	6 2006	BARI)	K A										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** HOrowit June 2006 3 55 AM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore lt ospital CI T The Johns Hopkins If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 5, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New York Days Hours 1₩ 2□F 84 052-16-2288 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Modeal Examiner must be notified at Y☐Yes 2☐No Rockville Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 5800 Nicholson Lane, # 507 U. S. A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No White Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced WW 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. U. S. Government Statistician bepartment of Health and Mental Hygis no cream. If Heam 27 is marked other 1 by injury or other traumatic event, the case. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Fannie Brown Louis Horowitz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5800 Nicholson Lane, # 507, Rockville, Maryland Claire P. Horowitz - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 6/15/2006 Adelphi, Maryland * 4 □ Donation 5 □ Other (Specify) Mount Lebanon 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction 4 days **Physician** /Medical Due to (or as a consequence of) **Examiner** fneumon i a <u>-unaal</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine rimi and use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy 2□ No 1 Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death.
unerel Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours at To the Funerel D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce Res - 000 June 12, 2006 12 Yolanda Hendley , The Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 15

DHMH 17 Rev 1/2001

Registrar

Mary Antonia Hammett

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State		ate of Mary	iana, b	Certifica	ate of L	Death	. ,		Reg	No.	081	3046
Physician	1. Deceder	nt's Name (First, Midd								Date of Death Month	Day Y	ear	3. Time of Death 1831 hrs
Medical Examine		ry Ar	ntonia on, give street and		mett	4b	. City, Town, or	Location of		June 10, 20	4c. Count	y of Death	10011115
	2255	Newtowne 5 Newton Neck F	Road				Leonardtow	/n			St. Ma	ry's	
Funeral Director	5. Social S	ecurity Number	6. Sex	1 -	yrs. last birt	nday)	If Under 1 Year Months Day		Min.		`	Foreign	
Director		50-9650 dence of Decedent	1 M 2 X F		78	Yrs.				05/15/1	.928	Wast	l'Ington, DC
any .	10a. State	10b. County		10c.	City, Town	or Location	1						10d. Inside City Limits
Maryland 28a-f show any d at once.	Mary1	and St.	Mary's_					nardt	own				1 Yes 2 XNo
ith the Maryland 23a or 28a-f sho notified at once	10e. Street	and Number					10f. Zip Code			100	g. Citizen of V	Vhat Counti	ry?
21215-0036 Jid be filed within 72 hours after death with the Maryland Mental Hygiene, marked other than "natural", or items 23a or 28a-f shing event, the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be notified at once in the Medical Examiner must be not interest.		555 Newtow Status		Road ecedent Ever	r in U.S.	13. Was	206 Decedent of His		in? (Speci	fv Yes or No-	United		en Indian, 8lack,
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safter d	3 X Wid		vorced If Yes, Give Y	ear			es 2 X No		industrial		Specify	*****	
5-0036 led within 72 hours afte ttygiene other than "natural", the Medical Examiner	15. Dece	dent's Education (Spe ary/Secondary (0-12)		(1-4 or 5+)			Usual Occupat t of working life				16b. Kind of E	Business/Ind	dustry
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Hygic d other		s Name (First, Middle						18.Mother's		irst, Middle, Ma		ne)	·
2121! ould be fil d Mental F s marked ic event,		rt Kermick	Hayden Ship (Type, Print)		198	. Mailing A	ddress (Stree	et and Num		Mae Ry al Route Numb		wn, State, 2	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other trannatic event, the Abdulant Table Comput.	Char	les Franci	s Hammet				Moll Dy						
or Heal		od of Disposition ial 2 X Cremation	n 3 Removal			of Dispositions of Disposition of Di	on (Name of ce r place)	metery,	D	ate	20c. Location	n - City or T	own, State
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Balt permit Departi Import injury		ward N. Br	insfield	ノ Ir	MOOOS		ne and Address		DITI				ome, P.A. 0 20650-027
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		lecedent pregnant in t 2 months?	he 1 Live	e birth	2	Feta	death 3	Ectopic	pregnancy	/	Month	Da	y Year
Box 68 death certif the attending	5 L		known	gnant at time known	of death	Othe	r (Specify)				Î		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the timeral director, page 2 should be detached for use as	Part II. Oth	ner significant condi	tions contributing	to death but	t not resulting	g in the un	derlying cause	given in Pai	rt I.	23e. Did tob	acco use con	tribute to th	e cause of death?
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Division of Vital Records, and or Attending Physician: The law require as after death. al Director: After this certificate has been signed in by the fineral director, page 2 should be as a contract of the fineral director.	5						60 DI	.		1 ✓ Yes 2	No	1 Yes	2 No
Vital Rechysician: The Ithis certificate I director, page	25. Was can examin		Hospital: 1	Inpatient	2 ER/0	utpatient		of Death (Nursing H		esidence 6	✓ Other:	Scene
n of V	27 Manne	r of Death	28a. Da	ite of Injury	28b.	Time of Inj	ury 28c Inju	iry at Work?	? 28	3d. Describe ho	w injury occu	irred	
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Hospit 24 hour Funera			Physician: To the b		owledge, dea	ath occurre	d at the time, d	ate and pla	ce, and du	e to the cause	(s) and mann	er as starte	d.
To the Hos within 24 h To the Fur completely	one)	2 Medical Exa	aminer:On the bas and manne		ition and/or i	nvestigatio			curred at th				
	29b. Signa	ature and title of certifi	er ,	M			29c. Licens				29d. Date sig June 11,	·	h, Day, Year)
	30 Nome	and address of person	n who completed o	ause of death	(Item 23a)			.41,			ount II,		
6		and address of person In Hogan MD.	Assistant Med			11 Penn	Street, Bal	timore, N	/ID 2120)1			
Sta	te 31. Date fi	led (Month, Day, Year JUN 2	9 2006 32.	Fistrar's S	ignature	-	- N				-		
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			1 - For Stete Registrar	State of M	aryland	•	ertment of tificate o			lental Hy	giene Reg. No.	006	20470
	Physici	an	1. Decedent's Name (First, Middle, Last)	A 1	7.7					2. Date of De Month	ath Day	2006 ^{Year}	3. Time of Death
	/Media	al	Keith	Andrew		ayes	45 Cit. Territ		tion of Donth	June :			02:02 a ^M
	Examir	er	4a. Facility Name (If not institution, give s Gilcrist Hospice				Tows		cation of Death			ounty of Deatl Baltimo	
	Funeral		5. Social Security Number 6. Sex	7. Ac	e (In yrs. la	ast birthday)	If Under 1 Ye	ar If	Under 24 Hrs.	8. Date of Bir	th		nplace (State or Foreign untry)
	Director		218 - 96 - 3825	M 2□F	25	Yrs.	Months Day	ys l	Hours Min.	Jan 28	, 198	1 Mar	yland
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Maryle f eho	ō	Maryland Howard		,		mbia					:	1⊠Yes 2□No
	r 28e-	rect	10e. Street and Number				10f. Zip Cod	е			10g. Citize	n of What Co	untry?
	th with	alD	6506 Beechwood Dr	rive			2	2104	1 6			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ADGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:	,		Was Decedent of f Yes, specify C I □ Yes 2XI		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Ame Black, White pecify:	
Baltimore, Maryland 21215-0036	ithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		5+)		dent's Usual Ockind of work do		n ng most of work	ing	16b. Kind	of Business/I	industry
nd 21	be filed w tal Hygier d other tl	Be	17. Father's Name (First, Middle, Last) Stephen Richar	d Hay	A 9		VCI NOI		. Mother's Nam Virgini		, Maiden Si OVanna		loran
Z Za	d Meni	To.	-		C3	105 14-15							
a ⊠	id 2 sk ith and 27 ks n traun		19a. Informant's Name/Relationship (Type Mrs. Virginia Hay		er				ourt, Fr				
5	f Healitem		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of			Date		tion - City or	
Ē	Page nent o ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St.	John'	s Cemet	ery	⁷ Jun 26	, 2006	Fred	derick,	Maryland
Balt	permit. Departitimport		21. Signature of Funeral Service License	hem	MOO7	06 1 0	Keeney 6 East	dess f	Sasford Irch St,	P.A. Fu	meral	Home Maryla	nd 21 7 01
	Physician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart fail re. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each li	d the death ine.		er the mode of a		such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
N. 8760, .	ate be executed ax shring shri	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):	7						years
.O. Box 6	eath certifi ettending i for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 □Fetal	death 3	Ectopic pregna				23	d. Date of deli Month	very Day Year
rds, P	quires that en signed b uld be dett	þ	Part II. Other significant conditions con	tributing to death b	out not resu	iting in the u	nderlying cause	given i	n Part I.	23e. Did 1	V		the cause of death?
Division of Vital Records, P.O.	The law resate here	Completed								24a. Was auto perio 1 \(\text{Yes}		prior to c death?	topsy findings available ompletion of cause of
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?	ospital:				O#	3. Place of Deat			27	
on of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, paga	ition: To	1 Yes 2 No 27. Manner of Death 1 Noatural 5 Pending 2 Accident investigation	1 ☐ Inpation 1 ☐		ER/Outpatien 28b. Time of Injury	28c. lr	njury at Vork?	4 ☐ Nursing Ho	ome 5 ☐ Resi 28d. Describe			dy) flospice
Divisi	s after dea s Director al Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	jury - At hor tc. (Specify	me, farm, str	eet, factory, offi	Ce		28f. Location (City or To	Street and I wn, State)	Number or Ru	ral Route Number,
	To the Hospital of within 24 hours at To the Funeral D completaly filled in	Medical	29a. Certifier (Check only one) CHOCK Only 2 Medical Examination	icien: To the best er: On the basis of and manner st	of examinati	wledge, death ion and/or in	occurred at the restigation, in m	e time, iy opini	date and place, on, death occur	and due to the red at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and title of certifier				29c. Lic					signed (Month	
	1		, mm	~~~			V	20	36-		JV/V	15	LICLO
_	4		30. Name and address of person who co	es, ms (2601	23a) (Type,	Print) Novle	1 1	r Bn	mue	wo	21204	200%
	Sta Regist		31. Date filed (Mosth, Pay Year)	32 Registi	rar's Signat	ure	and a						

State of Maryland / Department of Health and Mental Hygiene 2067 For Stata Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician MICHAEL **DOUGLAS** HOWES JUNE SR. 13 2006 1:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6001 Muncaster Mill Road-Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 579 01 3495 93 Director 10,1913 Washington, D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at MD. MONTGOMERY WHEATON 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11505 NEWPORT MILL ROAD 20902 UNITED STATES filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: W.W. II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROGRAM ANALYST U.S. GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event space. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM OLIVER HOWES **AGNES** MURPHY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MARGARET W. HOWES, WIFE 11505 NEWPORT MILL ROAD, WHEATON, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN 6/16/06 4 ☐ Donation 5 ☐ Other (Specify) SILVER SPRING, MD. 21. Signature of Funeral Service Licensee 22 MURIEC Add Has of BARBER FUNERAL HOME muriel Barker 20882 P.O. BOX 5038, LAYTONSVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RECURRENT PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ★Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE Hospital: 2 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29c. License numbe 29b. Signatu e and titl of 29d. Date signed (Month, Day, Year) D35635 JUNE 13, 2006 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers JOSEPH KAPLAN, M.D., 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD. 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 5008

			1 - For State Registrar	State of Marylar	nd / Depa	artme		ealth an		ntal Hyg		2005	20472
4,	1	* 1	1. Decedent's Name (First, Middle, Last)						2.	Date of Dea Month	ith Day	Yeer	3. Time of Death
	Physici /Medi		William J. Henegha	n, Jr.							13,	2006	6:55 a M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. Ci	ty, Town, or	Location of D	eath		4c.	County of Dea	th
			Montgomery Hospic	e- Casey Hou	se		Roo	ckville	9			Monto	gomery
	Funeral Director		5. Social Security Number 6. Sex 214-28-9674 Usual Residence of Decedent	7. Age (<i>ln yrs.</i> 79	. last birthday) Yrs.	If Un Month	der 1 Year ns Days	If Under 24 Hours	Min.	Date of Birth (Month, Day arch 2:	, Year)	Co	thplace (State or Foreign ountry) shington, DC
	Malylarid i-f show	tor	10a. State 10b. County		ity, Town or Lo								10d. Inside City Limits 1 Yes 2 XNo
	or 28g	Director	10e. Street and Number			10f.	Zip Code				10g. Citi	zen of What Co	ountry?
	23a	alc	13406 Grenoble D	rive			2085	3				USA	
020	perint. Pages I and 2 should be free writin 72 hours after used if will the maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Moulcal Examinar inter the notified at ODGs.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 XXes 2 □ No If Yes, Give Year or Dates: 194			cedent of Hi pecify Cuba 2 🛣 No	ispanic Origin n, Mexican, P Specify:	? (Specif uerto Ric	y Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify: Whi	e, etc.
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ם :	vent,	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (F	irst, Middle,	Maiden	Sumame)	
<u>a</u>	Venta Venta	To	William J. Henegh	an, Sr.					Jeanr	ne Mar	guer	ite Sau	ıber
Maryland	and h	ľ	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Addre	ess (Street a	and Number o	r Rural R	oute Numbe	r, City o	r Town, State, 2	Zip Code)
Σ ;	alth 27 I		Janet H. Opar/ Dau	ghter	3904	1 Ch	erry V	Valley	Driv	re, 011	ney,	MD 208	332
Baitimore,	nent of He ant: If iten ury or oth		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, create te of F	matory o	or other plac			ne 16		ver Spr	Town, State
Dall	Departr Departr Importr any inji		21. Signature of Funeral Service License	98				SCOILIT Sity Bl			Hom	e Inc	, MD 20901
	Physician /Medical Examiner	Examiner	23a. Párt1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):			g, such as can		sspiratory an			Approximate Interval Between Onset and Death
	the attending phrached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3[death 5[Other	c pregnancy (specify)		-	23e. Did to		23d. Date of del Month	ivery Day Year
Records,	w requires that been signed to should be det	ted by					g cadsb give				es 2x1		robably 4 Unknown
משר ובי		e Completed	25. Was case referred to medical							24a. Was a autop perfor 1 Yes	sy med? 2 12/10	prior to death?	utopsy findings available completion of cause of
	To the nospital or Attending Priystories, within 24 hours after death. No the Funeral Director: After this certifics completely filled in by the funeral director.	To B	avaminar?	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injun Work	er: 4 🗌 Nursir	ng Home	5 Resid	ence (city) Hospice
	s after deal al Director: ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	reet, fact			28f	Location (S City or Tow			ural Route Number,
:	the nospital or thin 24 hours after the Funeral Dir mpletely filled in	Medical (29a. Certifier (Check only one) 2 Certifying Physical Examination (Check only one)	ician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurr vestigat	ed at the tim	ne, date and p pinion, death o	occurred	due to the cat the time, d	ause(s) late and	and manner as place, and due	s stated. to the cause(s)
i	within comple	Me	29b. Signature and title of dertifier				D356					e signed <i>(Monti</i> June 13	
<u> </u>	1		30. Name and address of person who co Joseph Kaplan, M.	D. 6001 Mili	ncaster	- Mi	ll Roa	ad, Roc	kvii	le, MI	20	855	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 14 2	32. Pigistrar's Sign	atue	can	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 P. **Physician** Holland Granville June 12, 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wicomico Salisbury 713 Priscilla Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yee 3/15/1932 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1[XM 2□ F 74 213-26-5036 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ral', or items 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 713 Priscilla St. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 X Married If Yes, Give Navy Year or Dates: Navy 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced white "natural", ar then "neture the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Waterman/drywall contractor Seafood/construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked of traumatic ever Ida Meredith Aubrey Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tment of Health a tent: If item 27 is jury or other trail Norman Holland/son 713 Priscilla St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit, Pagi Department Importent: If any injury or Salisbury Crematory 6/14/06 Salisbury, MD * 4 ☐ Donation 5 ☐ Other (Specify) 24 Signature of Funeral Service I censee 2HoTloway Tuneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 14 K 22a Part. Enter the disease, or complications that caused a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner MON N (0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) Physician/Medicai the as the attending IF FEMALE use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ö in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No ij. 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

To the Hospitel or Attending Physician:

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

the Maryland

with

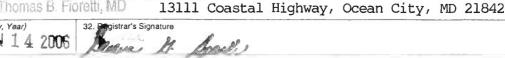
death y

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

29b. Signature and title of ce

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)



State Registrar Trinh

29c. License number

29d. Date signed (Month, Day, Year)

2006

			1 - For Registrar	State of	Marylan		artment rtificate			and M	lental Hy	ygien Reg. N	2000	20	1, 74
	Physici	ian	Decedent's Name (First, Middle								2. Date of D Month	Da	ay Year	3. Time o	
	/Media	ċal	Margaret Etta H 4a. Facility Name (If not institution		ner)		4h Cihy T	own or	Location o	f Doath	June 1		2006 c. County of Death	3:45	P ^M
	Examir	ier	Chesapeake Woo		,,,			nbri		Death			orchester		
	Funeral		5. Social Security Number		. Age (In yrs. I		If Under 1		If Under 2	24 Hrs. Min.	8. Date of B (Month, D			place (State	or Foreign
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Maryland	M ti		10a. State 10b. County		10c. City	, Town or Lo	cation						<u>-</u>	10d. inside C	ity Limits
	a-f e	ctor	Maryland Dorche	ster	Hur]	Lock								1 X Yes	2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip 0	Code					itizen of What Cou	intry?	
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ď	rlten	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Forc	es? M∑No					, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White		
5-0036 /	rel', o	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1□Yes 2	XI No	Specify:			j	Specify:	White	
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ם י	ital Hygiene. dother then "neturel", or items 23e or 28e-f ehow event, it a Medical Eranifor must be notified at	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	e, Maide	n Sumame)		
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	f Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relations										or Town, State, Zi		
a 6	f Health item 27 I		John Moore/Nepl 20a. Method of Disposition	new	20b. PI	ace of Dispo emetery, cren					ate		yland 21 ocation - City or T		
	nt: If i		1 🖾 Burial 2 ☐ Cremation 1 4 ☐ Donation 1 5 ☐ Other (S)			emetery, cren Sy Wasl				/15/	2006	Hur	lock, Ma	rvland	
Baltimor	Department of Inportent: If ite eny injury or of once.		21. Signature of runeral Service		11.						P. O.				
D 8	70 = 9 9	1	Honard	1 yel	ker	10	06 Mai	n S	treet	, Ea	st New	Mar	ket, MD	21631	
-			23a. Part1. Enter the disease, or Shock, or heart failure. List Immediate Cause (Final	complications that cau only one cause on eac	ised the death th line.	i. Do not ent	er the mode	of dying	, such as o	cardiac o	r respiratory a	arrest,		Approximat Interval Bet Onset and	ween
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َ وَ	ng phy as thi	70	IF FEMALE:												
TO THE	been signed by the attending pl should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 🗀 Fetal	death 3	Ectopic preg						23d. Date of deliv		Year
that the death	the a	ysic	1 ☐ Yes 2 ANo 9 ☐ Unknown	4∐Pregnar 9☐Unknow	nt at time of de	eath 5	Other (spec	cify)					100000	Duy	1641
	ned by e deta	by Ph	Part II. Other significant condition				nderlying cau	ise giver	n in Part I.		23e. Did	tobacco	use contribute to t	he cause of o	leath?
ecords,	en sig ould b	ted to	1170	ERTEI	$\sqrt{S1}$	01					1 🗆	Yes 2	□No 3□Prol	bably 4 t	Jnknown
e c c	as be	Completed									24a. Was	psy	24b. Were auto	opsy findings impletion of c	available ause of
The Tr	icate h		7								perfe 1 ☐ Yes	ormed?	death?	2 No	
OI VITAL	certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	entions 2 🗆 f	ER/Outpatien		Other	_		Check only		2.570.1		
o 4	ter this neral d	-	27. Manner of Death	28a. Date of		28b. Time of Injury		c. Injury Work		1	8d. Describe		6 ☐Other (Special occurred	'y)	
VISION	or: Af the fur	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation		пцату	М		es 2 □ N	lo					
	Direct Direct in by	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 28e. Place of	Injury - At hor , etc. (Specify	me, farm, stre	eet, factory, o	office		2	8f. Location (City or To	Street ar wn, State	nd Number or Rura e)	al Route Num	ber,
spite	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifyin	g Physician: To the be	est of my know	viedge, death	occurred at	the time	e, date and	l place, a	nd due to the	cause(s) and manner as s	tated.	
he Ho	in 24 h he Fu pletely	edical	(Check only 2 Medical E	examiner: On the basi and manner	is of examinati	ion and/or inv	estigation, in	n my opi	nion, death	h occurre	ed at the time,	date and	d place, and due to	the cause(s)
Tot	To t	Σ	29b. Signature and title of certifier		0				number	00			ite signed (Month,	Day, Year)	
			Matchter	M	D	00-1 (7							114106		
			30. Name and address of person v	O .	or death (Item	23a) (Type, I	1BP11	Mal	bbuba	Akh	ter, M	77%	13		
2. 30	Sta		31. Date filed (Month, Day, Year)		istrar's Signati	ure a.	1		/_	1-1		. 0	~		
	Registr	ar	den.	T o CANO	La Source	10	AND A								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	1	R	eg. No	106 204 i
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Last)		2. Date of Dea Month June 12, 2	Day Year	3 Time of Death 2241 hrs
The Land		4a. Facility Name (if not institution, give street and number) 4b. City, To sykes 1176 Heathfield Road Sykes	own, or Location of sville	Death	4c. County of I	Death
Funeral Director		214 76 7296 1XM 2F 49 Yrs. Months	r 1 Year If Under S Days Hours	24Hrs. 8. Date of Bir 02/14	İF	9. Birthplace (State or Foreign Country) MD
Maryland 28a-f show any d at once.	o	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10f. Zip	^{Code} 21784	1	Og Citizen of What United	
ter death w ", or items er must be	y Funeral		nt of Hispanic Origin Cuban, Mexican, F X No specify:	n? (Specify Yes or No Puerto Rican, etc.)	14 Race - A White, e Specify:	American Indian, Black, etc. White
11215-0036 Id be filed within 72 hours afte Aental Hygiene. narked other than "natural", event, the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman			16b. Kind of Busin	
21215-0036 uld be filed within 7 Mental Hygiene. market other that	Be Cor	Robert Joseph Hampton		Name (First, Middle, M		
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	ပ	Joseph C. Hampton/Brother 616 Silve	r Maple C	Circle Seve	en Valley	rs, PA 17360
re, stan		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Nam crematory or other place) Metro Cremato		Date 6-14-2006	20c. Location - Ci	
Baltimo permit. Page Department of Important: injury or oth		21. Storeture of Funeral Service Licensee M01044 22. Name and A112 01.	Address of Facility Address of Facility	Harry H. Wi La Pike El	itzke's F licott Ci	amily FH Inc. ty, MD 21043
Physician /Medical Examiner	n 0	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Arteriosclerotic cardiovascular)		diac or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death
territoria de la companya del companya de la companya del companya de la companya		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	Examiner	if any, leading to immediate raure. E. for U. denyl is Coure (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				_
760, frate be executed g physician and the burial - transit			7/5/06 TT			
	n/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death		pregnancy	23d, Date of de Month	elivery Day Year
P.O. Box 68 s that the death certing and by the attending detached for use as	Physicia	past 12 months? 4 Pregnant at time of death 5 Other (Specific Specific)		í l	- 51	
33 Lan 9	ģ		cause given in Part			te to the cause of death? Probably 4 Unknown
The page	Completed			24a. Was a autop perfor 1 🗸 Yes	sy prio med? dea	re autopsy findings available or to completion of cause of oth? Yes 2 No
Vital Rechysician: The this certificate	Be (25. Was case referred to medical examiner?	6.Place of Death (C			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	ition: To	27 Manner of Death 28a Date of Injury 28b Time of Injury 2	Bc. Injury at Work?		now injury occurred	Other Scene
Divisi pital or Att ours after de neral Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide General Place of Injury - At home, farm, street, factory, (Specify)	office building, etc.	28f, Location (S or Town, S		or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		opinion, death occu			
	Σ	(larfalery)	O.C.M.E.	•	June 13, 200	(Month, Day, Year)
SITM		Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner	Baltimore, MD	21201		
Si Regis	tate trar					
DHMH 17 Rev 1/2		2 2000 1-4000				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Day **Physician** 9 2006 MARIE A. HADDAWAY 12:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT 8. Date of Birth (Month, Day, Year) JAN 23 1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 F Months Days MARYLAND 80 213-28-3858 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23e or 28a-f show the Madical Examiner must be notified at Yes 2 No Director MD TALBOT TILGHMAN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21471 COOPERTOWN ROAD 21671 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: ģ 3
▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) HOMEMAKER OWN HOME Department of Health and Menner Important: If item 27 is really injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN FOERTSCHBECK MARY HAMMEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 DUNE GRASS DRIVE, BERLIN, MD 21811 ROLAND D. HADDAWAY III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State TILGHMAN MEMORIAL CEM 6/15/2006 1 4 ☐ Donation 5 ☐ Other (Specify) TILGHMAN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Wasph M. Ostrowski C.f. S./4 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Meta stal disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence (Specify) 2 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ANatural 1 Yes 2 No 2 Accident Director 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🔲 Homicide e Funeral 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the the 29c. License number 29d. Date signed (Mosth, Day, Year) 29b. Signature and title of g 2 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 2 2006

1			1 - For State Registrar	State of Maryla	and / Depa	artment <i>rtificate</i>	of He	ealth and Death		Reg. No.	UU6	20477
10	Physici		Decedent's Name (First, Middle, Last, KENNETH L. JOH) INSON					2. Date of De Month 05–28-	Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give HEARTLAND HOSPICE			4b. City, To		ocation of Dea		4c. C	ounty of Death	10:00 AM
	Funeral Director		5. Social Security Number 6. Set 579-04-4954 Usual Residence of Decedent	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hr. Hours Mir			9. Birth	place (State or Foreign intry) n.W.Va.
	the Maryland 28a-f ehow nutified at	Director	Maryland Prince Geo		City, Town or Lo					10c China		10d. Inside City Limits 1 Yes 2 □ No
	h with		16703 Dorchester I	Place		101. Zip C		772		rug. Citize	n of What Cou USA	intry?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or itema 23a or 28a-1 ehow event, I'ra Medical Eratri har routile a routiled at	d by Funeral	11. Marital Status 1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ★ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceder	nt of His Cuban		Specify Yes or No to Rican, etc.)		. Race - Ameri Black, White	
Maryland 21215-0036	within 72 h ene. then "natu he Medicel	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e <i>completed)</i> College (1-4or 5+) 01	(Give	DO NOT use	done du retired)	ring most of wo	orking		of Business/Ir	ndustry
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	01	ASST.	OIII		anager 8. Mother's Na	me (First, Middle	Priva , Maiden Su		
ylar		To B	Tony Smith					Juanit	a Walker			
Baltimore, Mar	t and 2 deelth a om 27 to her tra		19a. Informant's Name/Relationship (Ty, Juanita Walker/mot 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	ther 206	16703 D. Place of Dispo cemetery, cren	Dorch sition (Name natory or other	nest	er Plac	e Upper Date 1–2006	Marlb 20c. Loca	oro, Mo	1 20772 own, State
Balti	permit. Peges of Department of History of Manager 1, 11 items on yinjury or of Once.		21. Signature Fun ral Service License		22	. Name and	Address	of Facility				I,Md. 20746
8760,	Cate be executed /Medical Examiner s the burial-transit	dical Examiner	23a. Reff. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	HEAD AND Due to (or as a cons ATDS Due to (or as a cons Due to (or as a cons	NECK CA) equence of):							Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific tate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1□Live birth 2 □F6 4□Pregnant at time of 9□Unknown	etal death 3	Ectopic pregi				23d	l. Date of delive	ery Day Year
ords, P.	w requires that to be the signed by should be detained	ed by Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	derlying caus	se given	in Part I.		obacco use		ne cause of death?
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<u>=</u>	ysician s certil directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA			ath Check only o		10u 10	
ion of	ding Ph After th funeral	atlon: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)			injury a Work?	s 2 \(\text{No}\)	28d. Describe h			/)
DİVİ	in Diffic	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)				City or Tow	vn, State)		l Route Number,
	- 4 - 0	Medical	one)	ician: To the best of my k ler: On the basis of examil and manner stated.	nowledge, death nation and/or inv	estigation, in	my opin	ion, death occu	, and due to the ourred at the time, o	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)
)	To the within Comple	~	29b. Signature and title of certifier	Jum		_	cense n				gned (Month,	
0	(2)		30. Name and address of person who con	mpleted cause of death (It	em 23a) (Type. F		52	.org		SUM	e 01,	2006
	3/		DIVYA VERMA, MD	7525 Greenwa	v Cente	r Driv	e 0	reenbel	t, Mary	land	20770	
	Star Registra		31. Date filed (Month, Day, Year) JUN 1 4 2006	32. Registrar's Sig	nature	e e						

			1 - For State Registrar	State	of Marylar		artment of		d Mental Hyg	iene	106	201	.79
	D		1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat	1		3. Time o	f Death
	Physici /Medio		Bonnie	Jean J	ones				June	Day 13	2006	6:50	РМ
	Examir		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town,	or Location of D	Death	4c. Cour	nty of Death		
			10500 Mox1ey	Road			Damaso	cus			Montg	omerv	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under 1 Yea Months Day:		Hrs. 8. Date of Birth Min. (Month, Day,	Year)		lace (State	or Foreign
	Director		225-44-2853	1 U W 2 KU F	70	Yrs.			Sept. 8	, 1935	5 Virg	inia	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				11	0d. Inside C	ih, Limite
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	3a or	<u> </u>	10500 Moxley Ro	ad			20872		,	. CIII2611 0		,	
	me 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U	I.S. 13. V			? (Specify Yes or No-	14. R	U.S.A.		
ထ	or Ite	교	1 Never Married 2 Marr		2 🔀 No				? (Specify Yes or No- luerto Rican, etc.)		lack, White,		
8	Durs a	by	3 Xividowed 4 ☐ Divorced	If Yes, G Year or	live Dates:		I∐Yes 2∏ No	Specify:		Spec	ify: Whi	te	
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Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Rickd other than "natural", or iteme 23e or 28e-f show atic avent, it a Madical Examinar must be notified at	Be	17. Father's Name (First, Middle,					18. Mother's	Name (First, Middle, M.	laiden Suma	ame)		
<u>~</u>	should and Men marke umatic	2	Randall Ritte					Let					
<u>ā</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If the Marylan and Mental Hygiene. If the Marylan are deather than "natural", or Iteme 23a or 28a-1 ahow or other treumatic avent, the Mudical Examinar must be notified at		19a. Informant's Name/Relations						r Rural Route Number,				
o,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trei		Melissa Haas - 20a. Method of Disposition	Daughte		471	Swamp Ro	oad, Mor	gantown, P				43
Baltimore,	or o		1 ⊠Burial 2 ☐ Cremation		n State	cemetery, cren	natory or other pla			Oc. Location	n - City or Tov	wn, State	
₫	it. Partimer ritmer ritmer njury		4 Donation 5 Other (Sa		Pr	oviden	ce Metho	dist 6	/16/06 <u>k</u>	Cempto	wn, Ma	arylan	ıd
Ba	Depa mpo mpo mny ii		21. Signature of Funeral Service	ercensee /	01 .) Me	. Name and Addi Oleswort	ess of Facility h-Willi	ams P.A., I	Tunera	1 Home	2	
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	n. Do not ente	er the mode of dy	ing, such as care	diac or respiratory arre	st,		Approximate Interval Bet Onset and I	ween
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a C c	plored	dal	Ca	ncer	-			4 40	ars
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	nsit	Examiner	Recuertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(01 43 4 0011394	derice oi).							
	axecu and al-tra	Xar	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):					_		
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89	illicate ig phy as the	olba		d							-		
ŏ	death certific ie attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna					234 D	ate of deliver	.,	
ň	d tor	Ca	in the past 12 months? 1 ☐ Yes 2 ☒ No		birth 2 ☐ Feta nant at time of d		Ectopic pregnand Other (specify) _	У				•	/ear
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J	law requires that the as been signed by the 2 should be detached.	by P	Part II. Other significant conditio	ns contributing to o	death but not res	ulting in the un	derlying cause gi	ven in Part I.	23e. Did toba	icco use cor	ntribute to the	cause of de	eath?
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r	6 4 90	Completed		-					 autopsy performe 	ed?	. Were autop: prior to com death?	pletion of ca	iuse of
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5 ∶		0.0	examiner? 1 ☐ Yes 2 XNo	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Ot		Death <i>(Check only one)</i> g Home 5 ⊠ Residen		has (Casa 6.)		
	grnys erthis eral di	n: T	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Inju		28d. Describe how				
DIVISION	Attending is death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investig		nth, Day Year)	Injury		rk?]Yes 2∐No					
SIN	atter death atter death Director: d in by the	1110	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	e of Injury - At he ling, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Stre	et and Num	ber or Rural	Route Numb	ber,
5	s afte	Certification:	· L · · · · · · · · · · · · · · · · · ·	Dalla	ing, etc. (Specii)	Y)			City or Town,	State)			
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1	i i i i	ledical		and mar	ner stated.	non and/or inv			ccurred at the time, dat	e and place.	, and due to t	he cause(s)	
	To To	Σ	29b. Signature and title of certifier				29c. Licens		290	I. Date signe	ed (Month, D	ay, Year)	-
	n		1 2 2	e mi)			1142	2641	, J	une 1	4, 200	6	
	3		30. Name and address of person v		1: ~	4	Print)	2-	1 -	1		D	
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	Star Registra	e ar	31. Date filed (Month, Day, Year)	6 2006 32.5	gistrar's Signa	W A	sorte						

State of Maryland / Department of Health and Mental Hygiene 🦙

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** LAWRENCE JOHNSON, JR. 06 13 2006 08:50 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 32042 JORDAN COURT SALISBURY WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthptace (State or Foreign **Funeral** 1**X** M 2□ F Yrs. SALISBURY, MD. 48 Director 220-68-9978 Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo SALISBURY WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23s or 32042 JORDAN COURT permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or Items 23s eny Injury or other traumatic event, tre Modical Examinational poince. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No ģ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 AUTO PARTS COMPANY DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DELORES "DODIE" DARBY LITTLETON LAWRENCE L. JOHNSON, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32042 JORDAN COURT, SALISBURY, MARYLAND 21804 DEBORAH JOHNSON - SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRINGHILL MEM. GDNS. 06-17-2006 | HEBRON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature V Funeral Service Lice 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Enter the disease, or complications that quised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell Oncer of the Lung Metastatic 5 mos /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending phase the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2₩ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₹ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024986 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 Riverside Dr. Bloi Salisbury Md. 21801 Robert Reilly MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 20482 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 2:00P M KING JUNE 07, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Min 1 □ M 💥 🕅 F Months Days Hours Director 577 48 7385 71 JULY 31, 1934 VIRGINIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f ahow traumatic event, the Medical Examiner must be notified at XXYes 2 No Director MD KING & QUEEN NEWTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itema 23a 11821 NEWTOWN ROAD 23106 UNITED STATES Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 ie marked other than "natural", or Itema 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK If Yes, Give Year or Dates: 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH PAYROLL SUPERVISOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be HUGH JOHNSON ELIZABETH BOOKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN KING / SON 3540 CRAIN HIGHWAY #317 BOWIE, MD 20706 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) JERUSALEM CHURCH CEM. 06/13/06 SPARTA, VA 21. Signature of Funaral Service 22. MARSHALLS SFRUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Crostric Camer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ronic ena1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 9 ~ S that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2□ No 1 Yes 1 Yes 2 X No Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28€No 1 SInpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 KNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 13PP200G 06 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MD 20785 MUKEMIL F. ABDELLA, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 1 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🔀 🗓 👸 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Haven Kolb Jr. June 16_ 2006 6:48 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Days Hours 216-20-8793 Director 90 05-07-1916 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ir than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18925 Gunpowder Road 21102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW]] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Η. Kolb Sr. Fannie E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 ie eny injury or other treu once. Dorothy Vicari - Daughter 108 N. Beechwood Ave., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State p☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Abraham's Cem. 4 □ Donation 5 □ Other (Specify) 06-22-06 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home 21. Signifure of Funeral Service Licenses MOO550 934 S. Main St., Hampstead, MD 21074 otana 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as ettending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an nem certificate 1 ☐ Yes 2 40 Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Dinpatient ဥ 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospitei or Auterion...
within 24 hours after death.

To the Funerel Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and IN 29c. License number
.) - 00542(8 of person who completed cause of death (Item 23a) (Type, Print) Malcalm duty, West munity MD 2/159 31. Date filed (Month, Day, Year) JUN 19 2006 State Registrar

			For State Registrar	State of M	laryland	/ Depa	rtmen tificat	t of He	ealth a	and M		Reg. No.	2006		204	
*	Physicia	an	Decedent's Name (First, Middle, Last, ATT TITE CO.								2. Date of De Month	Day		ır	. Time of I	
	/Medic	al		EWIS	-1		4b Ciby	Town or	Location of	f Death	May 2		06 County of De		:45	РМ
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	Funeral		5. Social Security Number 6. Sec	x 7. A	ge (In yrs. las	st birthday)	II Under	1 Year	If Under		8. Date of Bir	h	ince G	Birthplace		r Foreign
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	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. l	Inside Cit	v Limits
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	r 28a-	rect	10e. Street and Number				10f. Zip					10g. Citi	zen of What	Country?		
	ath with the Marylar 23a or 28a-f show ust be nutitied at	Funeral Director	4320 Castle Tower	Court				206	95				USA			
	ems (Iner	11. Marital Status	12. Was Decedent	t Ever in U.S.	. 13. V	Vas Dece	dent of His	spanic Orig	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ar Black, W		ndian,	
36	s afte		Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give		1	I □ Yes						Specify: B1			
Ş	filed within 72 hours after death with the Maryland Hydione. Inter then "naturel", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent's Edu	Year or Dates:		16a. Deced	tent's Usu	al Occupa	tion				nd of Busine:		rv	
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21	be filed withital Hygiene.	Som	-O-								none					
=	m = 0 5	Be	17. Father's Name (First, Middle, Last)	r							e (First, Middle, da Wall		Sumame)			
<u> </u>	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, tre M	٦ و	Arthur Lewis, I			10h Mailie	Addross	/Ctract a					Town State	Zin Con	ofa l	
Maryland 21215-0036	nd 2 st lith and 27 ts n r traun		19a. Informant's Name/Relationship (T) Karlynda Wallace,			4320	Cast.	le To	wer	Cour	t White	Pla	ins, Md	1. 20	î695	
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta important: If item 27 is marked any injury or other traumatic evance.		20a. Method of Disposition 1	Removal from State	cen	ce of Disponetery, cren	natory or c	ther place			Date		cation - City		State	
<u>=</u>	it. Pa intmen intent: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Ceda	ar Hil			s of Facilit		-2006	Sult	land,M		746	
Ba	Depa impo any ir		Mary Hida and	M01374	ļ-					•	Penn.,	Ave.	Suit1			
			23a. Part1. Enter the disease, or complishock, or heart lailure. List only o	lications that cause	ed the death.					-				App	proximate erval Betv	e veen
	Physician		Immediate Cause (Final disease or condition	Extra	eme	In	ma	tur	1/4	1 -	21	wx	/	Ons	set and D	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque		· · · · · · · · · · · · · · · · · · ·									
		ner	if any, leading to immediate	b. Due to (or a	s a conseque	ence of):								-		
_	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a conseque	ence ol);										
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89	ng phy as th	Medi	IF FEMALE:													
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 ☐ Fetal d	feath 3□	Ectopic p					2	23d. Date of o Month	delivery Day	, Y	'ear
o O	at the de by the a stached f	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant : 9□Unknown	at time of dea	ith 5∟	Other (s	овсіту)								
ت	res that t igned by be detar	by Ph	Part II. Other significant conditions co	ntributing to death	but not result	ting in the ur	nderlying o	ause give	n in Part I.		23e. Did t	obacco u	se contribute	to the ca	ause of de	eath?
Sp	w requires been sign should be										10	/es 2	ZNo 3□	Probably	4 □U	Inknown
Records,	e law re has bee je 2 sho	Completed									24a. Was	sy	24b. Were	to comple	lindings a	available ause of
<u>e</u>											1 Yes	2 No	death 1 🗆 Y		No	
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Division of Vital	g Ph ler th neral	n; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In	iury 2	28b. Time of Injury		28c. Injury Work	4 🗆 140		28d. Describe			респу)		
<u>S</u>	Attendin er death. rector: Aff by the fur	catle	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	'es 2 □ I							
Ω		Certification:	4 Homicide determined	28e. Place of In building, e	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factor	y, office			281. Location (. City or To:			Rural Ro	ute Numi	ber,
	To the Hospitai or within 24 hours after To the Funeral Director completely filled in	Medicai (29a. Certifier 1 Certifying Phy (Check duly one)	sicien: To the bes	of examinatio	ledge, death on and/or inv	occurred vestigation	at the tim	e, date an inion, dea	d place, th occurr	and due to the red at the time,	cause(s) date and	and manner place, and d	as stated	i. cause(s))
	To the within 2 To the complet	₩	29b. Signature and title of certifier	1-1	M -	7	69	c. License	number				e signed (Mo		/	
			1 LIOHANA	ia	11:0	1	1	134	130	2		5-	29	-06	0	
K			30. Name and address of person who c	-	death Illeen 2			CI.	ראידי	MAR	YLAND 2	0735				
	Sta	ate.	JOSEPHINE VERGAR 31. Dave filed (Month, Day, Year)		US SUKI		KOMD	OIL.	LITTON	9 1 11 11						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lee 11, 2006 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/24/1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 M 2 KF Director 577-48-6889 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exercicer must be notified at MD Prince Georges Capitol Heights 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Nova Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. or items 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nri any injury or other traumatic event, Ina Media obce. 2 ^{College (1-4or 5+)} Elementary/Secondary (0-12) Licensed Practical Nurse Medica1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Johnson John Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, MD 20743 Cheryl Lee (daughter) 804 Nova Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetey 6/16/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Road, Authard Brentwood, MD 20722 nomeso 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FATAL CARDIAC Physician /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sete has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📈 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an this certificete has 2 No 1 ☐ Yes o the Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 724535 6-13-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAX MI BERWA, MD 1700 OLD BRAN CH BERWA, CLINTON, MD 20735 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 4 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year Lucille F. Lloyd June 2006 4 7:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14804 SilverstoneDrive Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 12 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 577-60-7203 98 Yrs Director 1907 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or itama 23a or 28a-1 show other traumatic event, the Modical Exempler of stat Lember 1 1X Yes 2 No Funeral Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14804 SilverstoneDrive 20905 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itama 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. I □ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 X Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 4 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Winter Ford Channie Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Sloane / Daughter 14804 SilverstoneDrive Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery June 12,2006 Washington, DC 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 Kennedy St. NW Washington, DC 20011 Denti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** ream /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical eral Director: Atter this certificate has been signed by the attending phys filled in by the funeral director, page 2 should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2☐ No autopsy performed? 1 Xes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3☐ DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) atricia 3 Na e and address of person while completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 3 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 20487 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day SADIE LEAKE B. JUNE 2006 6:13 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3209 BARCROFT DRIVE SPRINGDALE PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F Director 069-30-1918 82 AUGUST 29 1923 KENTUCKY Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I tem 27 ie marked other then "nature!" any fijury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No MD PRINCE GEORGE'S SPRINGDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3209 BARCROFT DRIVE 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 ŽÑo If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 4 No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th DISTRIBUTION PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHESTER GILL GERTRUDE HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS A. LEAKE SR./SON 3209 BARCROFT DRIVE SPRINGDALE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN HILL CEMETERY 6/17/2006 LAWRENCEBURG, KENTUCKY 21. Signature of Foneral Service J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) attending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tes 2 🗆 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete 1 ☐ Yes 2 No 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Massidence 6 Other (Specify) 2 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 (XNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funerel Dire 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLIN OTTEY M.D. 8601 MARTIN LUTHER KING HIGHWAY # 2 LANHAM, MARYLAND 20706 31. Date filed (Month, Day, Year) State JUN 1 3 2006 Registrar

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Ġ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among the propertiest of the propertiest of the propertiest in the Medical Evantment near be notified at once.		20a. Method of Disposition		20b.	Place of Dispo					ate		ocation - City o		
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Exami	ner	4a. Facility Name (If not institution, giv	e street and number)		4b. Ci	ty, Town, o	r Location of	Death			4c. County	of Death		
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7 or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	Removal from State	cemetery, crer hesapea		•	· 1	6/16	106			•		1 1
Important: If its any injury or or once.		21. Signature of Funeral Service Licen									1tsvi			Tand
any tr		1300 9 £ H	- () tt	Gö 01251Be					Servi					
nysician Medical Kaminer Itausii Ita prival Itausii Ita prival Itausii Ita prival Itausii Itau	dical Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	Colon C equence of):			g, such as c	ardiac o	respiratory	irrest,			Approxim Interval E Onset an Year	letween d Death
been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □	Ectopic (pregnancy specify)					23d. Dat Mor	e of delive	ry Day	Year
gned be det		Part II. Other significant conditions of	entributing to death but not re	sulting in the ur	nderlying	cause give	n in Part I.		23e. Did 1	obacco	use contr	ibute to the	e cause o	f death?
old,	E e		-						10	Yes	2 🙀 №	3 ☐ Proba	ably 4]Unknown
2 sh	Completed by								24a. Was					s available
page	5									rmed? 2 □ χΛ	d	rior to comeath?	ipletion of 2 No	cause of
director, page 2 s	Be	25. Was case referred to medical examiner?					26. Place o	f Death	Check only	$-\Delta$				
9 0	၉	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 [ER/Outpatien	3□ □	OA Othe	r: 4 🗆 Nurs	ing Hom	e 5 ☐ Resi	dence	6 XOthe	r (Specify	hos	pice
ner i	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	at ?	2	8d. Describe	now inj	ury occurre	ed		
he fu	cati	2 ☐ Accident investigation			М		es 2 No							
ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, stre ify)	et, facto	ry, office		2	8f. Location (. City or Tox	Street a vn, Sta	and Numbe te)	or or Rural	Route Nu	mber,
completely filled in by the funeral	Medicai	29a. Certifier Y☐ Certifying Phyone) 2☐ Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred	d at the time n, in my opi	e, date and pinion, death	place, a	nd due to the d at the time,	cause(date a	s) and mar nd place, a	ner as sta nd due to	ited. the cause	(s)
To the Funeral Director: completely filled in by the t	ž	29b. Signature and title of certifier			29	c. License	number			29d. D	ate signed	(Month, D	ay, Year)	
		Chihelyen	ne		D	42452				June	e 14,	2006		
Ina		30. Name and address of per in who c	ompleted cause of death (Ite	m 23a) (Tvoe F	Print)								_	_
Jm		Chitra Rajagopal,	•		,	l Rd.	Rocks	7 i 11	e. MD	2081	55			
Stat	е	31. Date filed (Month, Day, Year)	32. Poistrar's Sign	ature		1.4			-,					-
Registra	ar .	JUN 1 6 20	06	K L	4									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Joe William 2006 /Medical June 13 9:09P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 ☐ F Days Director 579-50-0184 66 Sept. 9, 1939 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9724 Huntmaster Road 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. other than "natural", or Ite 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 ff Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuaf Occupation (Give kmd of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home Improvements Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) permit. Pages 1 and 2 should be filed wi. Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, the once. Owner/Operator Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hilton Calvin Eleanor Louise Rest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9724 Huntmaster Road, Gaithersburg, Suzanne T. Lowe - Wife sburg, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematorium 6/16/06 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service icenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Therosclerate Coronary fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Records, P.O. Box 68760 ca Physiclan/Medi IF FEMALE 23c. ff yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital 1X Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2XNo 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0044362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MI Enrico A Grangeruso 18101 Prince Philip Dr., Olney, Md. 20832 31. Date filed (Month, Day, Year) 1 6 2006 State Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** (0:10 AM ALLENE R. LORD June /Medical ما 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Under 1 Year | If Under 24 Hrs. | 8 Manokin Manor 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 😾 F 218-20-6373 Director 79 Feb. 13, 1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 27 is marked other than "natural", or Itama 23a or 28a-f ahow traumatic evant, tra Madical Examinar must be molified at 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 ☑ No Somerset Crisfield Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26412 Silver Lane 21817 U.S.A. death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ita Black White etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Paint Brush Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton H. Butler, Sr. Anna Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Wooster (Sister) 27183 Hearts Ease - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. St. Paul's Cemetery 6/18/06 Marion Station, MD 21. Signatur 22. Name and Address of Facility Tr. Bradshaw & Sons Funeral Home Robert H. Bradshaw, 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 450VI) /Medical Due to (or as a consequence of) Examiner DVI Sequentially list conditions, and the sequentially list conditions, and the sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of) Examiner led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed? Vital 1□ Yes 2☐No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred To the Hospital or Attanding Injury 1 Natural 5 Pending death. М 1 TYes 2 TNo 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 12 Certifying Physician: To the best of my knowledge, death amounted at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NAHSUL 047094 6/16/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. NIVISION STREET V= ESAV 1415 101 31. Date filed (Month, Day, Year) State 2006 Registrar

06-03985 Please Type or Print in Black Indelible Ink Robert Scott Lambert State of Maryland / Department of Health and Mental Hygiene 2006 20492 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 10, 2006 1500 hrs **Medical Examiner** Robert Scott Lambert 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Civista Medical Center La Plata Charles 8. Date of Birth (MM/DD/YYYY) 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 9 Birthplace (State or 6. Sex **Funeral** Foreign Washington Months Days Hours Min Director 1 XM 09/28/1959 Country 2 F 46 217-72-7978 DC Usual Residence of Decedent Oc. City, Town or Location 10d, Inside City Limits any 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Bowie Maryland Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 USA 12532 Quarterhorse Drive Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Mantech 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Peggy Jean Crawford Thomas Wade Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 12532 Quarterhorse Drive Bowie, MD 20720 Cheryl Lynne Lambert/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Lakemont
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State Department of Important: I 06/15/2006 Davidsonville, MD Donation 5 Other Specify. permit 22. Name and Address of Facility Robert E. Evans Funera Home ervice Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part I. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Head and neck injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit Physician/Medical UNPENDED AMENDED ending physician use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown pe Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No. 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician; funeral director, 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes ဥ No 28a. Date of Injury FOUND: Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject motorcyclist in vehicular accident Natural FOUND: Yes 2 V No within 24 hours after death.

To the Funeral Director: Pending filled in by the Jun 10, 2006 1356 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Demarr Road , White Plains, MD determined (Specify) Field Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 11, 2006 30. Name and address of person who completed cau & o' death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) gistrar's Signatur State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death INE Month LOFTIS **Physician** 0221 M 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis HILL AND THE STATE OF 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2 SF Yrs. 224-32-5024 Virginia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic avant, Ira Medical Examilier must be neitified at once. Crofton 1 ☐ Yes 2X No Anne Arundel Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21114 2131 Davidsonville Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIII o If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo Baltimore, Maryland 21215-0036 Specify: Specify: 3 ₩ Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School System 8th School Bus Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nannie Lou Gilley Joseph Ransom Tilley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2905 Middlebridge Ct., Crofton, MD 21114 Curtis A. Loftis/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Greenwood Meml. Gdns. 6-23-06 Goochland, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature by Survey Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home "Ulle 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a/consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
-1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cete has been sign, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No fo the Hospitel or Attending Physicien: After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Ninpatient 2 ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21438 23 2006 use of death (Item 23a) (Type, Print) Name and address of person who MICHER TAMO 44T DEFENSE HIGHWAY AMAPOLISM DZIFOI 32 egistrar's Signature 31. Date filed (Month, Day, Year) State JUN 29 2006 Registrar

Physician Microl Scammer 4. Facility Name (for institution, give streat and number) 4. Facility Name (for institution, give streat and number) 4. Facility Name (for institution, give streat and number) 4. Facility Name (for institution, give streat and number) 4. Facility Name (for institution, give streat and number) 5. Sooil Security Number 5. Sooil Security Number 5. ST7-36-20724 5. Sooil Security Number 5. ST7-36-20724 6. Sax 7. Age (for yea, automosph) 10 Cay, Town on Location of Death Facility Name (for institution, give streat and number) 100. Clear of Name (for year) 100. Clear of Name (1 - For State Registrar	State of Mary		artment of			iene UU6	20499
4. Facility Name of the control of t				1. Decedent's Name (First, Middle, Last ROBERT E.		=			Month	Day Year	3. Time of Death
Discourse of the part of the p	E	xamin		HOWARD COUNT	Y GENER		PITAL	COL	HMBIA	4c. County of Deal	th ARD
Support Tentement Support Description	Dire	ector		577-38-9274 1 5 Usual Residence of Decedent	M 2□F {	36 Yrs.	Months Days			Year) Co	untry)
Principles Type of the princi	the Marytar 28a-f show	ixtified at	ector	Maryland Howa							10d. Inside City Limits 1 ☐ Yes 2 No
Principles Type of the princi	15-0036 in 72 hours after death with	ledical Examiner must be r	by Funerai	14557 MacClintock [11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WWI	II 16a, Deced	2173 Vas Decedent of I Yes, specify Cub	Hispanic Origin? pan, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	11SA 14. Race - Ame Black, White Specify White 6b. Kind of Business/	nican Indian, e, etc.
Privicion Medical Examiner Privicion Privicion Medical Examiner Privicion Medical Examiner Privicion Medical E	and 212 d be filed within ontal Hygiene.	c event, the M	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, M	Engraving &	
Privicion Medical Examiner Privicion Privicion Medical Examiner Privicion Medical Examiner Privicion Medical E	nore, Maryl ages 1 and 2 shoul nt of Health and Me	or other traumati	ř	19a. Informant's Name/Relationship (Ty A. Russell LaHayro/ 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	Scri 20	14557 b. Place of Dispos cemetery, crem	MacC intoc sition (Name of patory or other pla	t and Number or	Rural Route Number, Date 2	ryland 21738	
Privicion Modelical Examiner Part Modelical Examiner Modelical Ex	Baltin permit. Pa Departmen	any injury once.		21. Signature of Funeral Service License	Durker	Fr. 50	Name and Address ancis J. C O Universi	ory Collins Fu ty Blvd,	2006 neral Home In W, Silver Spr	nc. ring, MD 2090	2016-25-100-00-10-20
The familiary of deathy Last contributing in the underlying cause given in Part I. Impact	/Med	lical		Immediate Cause (Final disease or condition	. Jast	vinte	or the mode of dying	. 1 1		st,	Interval Between Onset and Death
The past 12 months? FFEMALE 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	8760, icate be executed physician end	the bu	lca	that initiated events	Due to (or as a con						
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-CHINGUYEN, MD FCCP 7350 Grace Drive, Columbia, MD 21044	of V hysic his ce	9 1			ospital: 1 hpatient 2	ER/Outpatient	3 DOA Oth		- C. F. C. II.	ce 6 ∏Other (Speci	fv)
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2011 D. M.D., FCCP D.36845 Tune 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-CHI NGUYEN, MD, FCCP 7350 grace Drive, Columbia, MD 21044	o the Hos ithin 24 ho the Fund	mpletely f		one)	er: On the basis of exam	knowledge, death unation and/or inve	estigation, in my o	pinion, death oc	curred at the time, date	e and place, and due t	o the cause(s)
	201	8		MMS, MD,		tem 23a) (Tuna P	D 2	6845	1	- 12	
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ı	Physic		 Decedent's Name (First, Middle, L. John Paul Land 						2. Date of E Month June	D	ay 006	ar	3. Time of Death 11:15 AM
	/Medi Examir		4a. Facility Name (If not institution, gi 1582 Comanche Ro	ve street and number) Dad		4b. City,		nold			c. County of D		
	Funeral Director			Sex 7. Age 71 71	(In yrs. last birthda Yrs	Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of E	Sirth Day, Year	35 9.	Birthplac Country Mary	e (State or Foreign land
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9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-1 ehow mith julyry or other traumatic event, the Medical Examinar must be redified at 200s.	þ	11. Marital Status 1 ☐ Never Married 2M Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ØYes 2 ☐ No If Yes, Give Year or Dates:	1057	3. Was Deced If Yes, spec 1 Yes		panic Origin , Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - A Black, V Specify:	American Vhite, etc. Whi	
1215-(within 72 h iene. • then "natu i're Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+ 5+	(Gi	cedent's Usua ive kind of wo b. DO NOT us vil En	rk done du se retired)	iring most of	working		Cind of Busin		•
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, Mary	1 and 2 should Heelth and Men 1em 27 is marke other traumatic	•	19a. Informant's Name/Relationship Marilynn Landis /		158	2 Coma	nche	Road	Arnold,				
Baltimore,	permit. Pages 1 an Department of Heel Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	(y)		n Nat'	1 Cer	n. 6/	Date 26/2006	Arli		Vir	ginia
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Lice	lom		147 Du	ke o	f Glou	cester St	. An			Home, Ind D 21401
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pan	Creasiconsequence of):	Ca	e of dying,	such as car	diac or respiratory	arrest,		Int	proximate erval Between iset and Death
8760,	rate be executed physician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):								
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Division of Vital Records,	ysician: The law re is certificete has be director, page 2 sho	Completed									prior death	to comple	findings available tion of cause of
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sion	Attending Physician: r death. ector: After this certifice by the funeral director, t	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			М		s 2 No	28d. Describe	now injur	ry occurred		
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	y sician: To the best of r niner: On the basis of ex and manner state	camination and/or	investigation,	in my opin	ion, death o	ace, and due to the ccurred at the time,	cause(s) date and	and manner d place, and d	as stated lue to the	cause(s)
	A William	-	29b. Signature and title of certifier	that me	2		License r	umber - 000		29d. Dar	te signed (Mo	onth, Day,	Year)
			30. Name and address of person who Teffrey R. Inta	completed cause of deal	th (Item 23a) (Type		fe	Stroct	Bultimo	12	MO)	7
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's	Signature	and a					3, 137	~~^	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 4 U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month HUBERT MCCREARY 2006 UNC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1∑M 2□F 248-22-9647 84 Yrs. 1922 SOUTH CAROLINA Director Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene: Important: if item 27 is marked other then "naturel", or items 23e or 28e-f ehoven't light yor other traumatic event, the Medical Examinar must be notified at 2008. 1X Yes 2 No Directo PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7611 BARLOWE ROAD 20785 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No BLACK þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NDT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 6th AOP INSPECTOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARTHUR **MCCREARY** BERTHA BRINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARRIE MAE MCCREARY/WIFE 7611 BARLOWE ROAD LANDOVER, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 6/17/2006 BRENTWOOD MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME K-D 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** HOUR disease or condition resulting in death) /Medical Examiner CHROCK OBSTRUCTIVE PUHIONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physicien and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 No 1 Yes 2□ No 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending Injury 1 Natural 5 Pending 24 hours after death. • Funeral Director: A М 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) Man, HD D0058275 06-13-06 larand u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 DOCTORS COMMUNITY HOSPITAL LANHAM, MD 20706 PARAND ALAVI, MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 4 2006

MCCREARY,

2. Registrar's Signature

			1 = For State Registrar	State of Ma	arylan				lealth a	and M	lental H	ygier Reg. N	LUUD	21	1499
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J.	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City	, Town, o	r Location of	of Death	JUNE		c. County of Dea		33 A
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27	Funeral Director		5. Social Security Number 6. S 367–18–7442	ex 7.Ag	e (In yrs. 86	last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of B	irth Day 191	9. Bir	thplace (Sta ountry) Mich	igan
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	z should be little within 72 thous arist bean with the maryands and Mently Hyglene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 4225 Southwinds Place #201			10f. Zip Code 20695					10g. (Citizen of What Ci USA	ountry?		
;		era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.		Was Decedent of Hispanic Origin? (Specify 'If Yes, specify Cuban, Mexican, Puerto Ricar			ecify Yes or I	No-	14. Race - American Indian,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Physician LUNE 2006 Moreno Slyvia Lynn /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hopkins 6. Sex Hospital Baltimore Johns If Under 24 Hrs. 8. Date of Birth (Month, Pay Year) 6/6/2006 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 ☐ M 2 💢 F Baltimore, MD Yrs none Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1X Yes 2 No Baltimore City Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 United States 219 S. Pulaski Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1X Yes 2□ No Specify: Latino Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Patricia Oxendine Jorge Moreno-Rengifo ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 219 S. Pulaski street Baltimore, MD 21223 Patricia Moreno 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1X Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Fort Lincoln Cemetery 6/17/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licania 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final PULMONARY HYPROLASIA 1 DAY

Physician /Medical Examiner

Funeral

Director

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with the Maryland

filed within 72 hours efter deeth

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Baltimore, Maryland 21215-0036

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				24a. Was an autopsy performed? 1 □ Yes 2	prior to death?	utopsy findings availabl completion of cause of s 2 No			
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3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact ify)	ory, office	28f. Location (Street City or Town, Sta	8f. Location (Street and Number or Rural Route Number City or Town, State)				
29a. Certifying Phy (Check only one) 2 Medical Exami	siciam To the best of my kn ner: On the basis of examin- and manner stated.	owiedge death securi ation and/or investigati	ed at the time, date and plan on, in my opinion, death occ	e and due to the dause curred at the time, date a	(1) and manner and nd place, and due	s thated e to the cause(s)			
29b. Signature and title of certifier			29c. License number	29d. [29d. Date signed (Month, Day, Year)				
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600 N. Wolfe Street

JOHNS HOPKING HOSPITAL BUILTIMORE, MD ZIZ87

DHMH 17 Rev 1/2001

State Registrar 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

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IUN 1 3 2006

JUSTIN L 31. Date filed (Month, Day, Year)